CCME

2021 External Quality Review

MAGNOLIA HEALTH PLAN

Submitted: November 30, 2021

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. This review determines the level of performance demonstrated by Magnolia Health Plan (Magnolia). This report contains a description of the process and the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN).

The goals and objectives of the review were to:

- Determine if Magnolia is in compliance with service delivery as mandated in the Coordinated Care Organization (CCO) contract with DOM
- Provide feedback for potential areas of continued improvement
- Ensure contracted health care services are being delivered and are of acceptable quality

The EQR process is based on Centers for Medicare & Medicaid Services (CMS)-developed protocols for EQRs of Medicaid MCOs. The review includes a desk review of documents; results from a two-day onsite visit; a compliance review; validation of performance improvement projects (PIPs) and performance measures; evaluation of network adequacy; member and provider satisfaction survey validations; and an Information System Capabilities Assessment (ISCA) review.

Provider Network Access Call Studies and Provider Directory Validations are conducted on a quarterly basis and are reported separately.

I. Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements are related to:

- Availability of Services (§ 438.206)
- Assurances of Adequate Capacity and Services (§ 438.207)
- Coordination and Continuity of Care (§ 438.208)
- Coverage and Authorization of Services (§ 438.210)
- Provider Selection (§ 438.214)

- Confidentiality (§ 438.224)
- Grievance and Appeal Systems (§ 438.228)
- Subcontractual Relationships and Delegation (§ 438.230)
- Practice Guidelines (§ 438.236)
- Health Information Systems (§ 438.242)
- Quality Assessment and Performance Improvement Program (§ 438.330)

To assess Magnolia's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration

42 CFR § 438.242, 42 CFR § 438.224

Magnolia manages policies using the RSA Archer® system for tracking and review notification purposes. Policies are applicable to all employees of Centene Corporation, its affiliates, and subsidiaries. Guidance for the development, review, approval, and maintenance of Company policies is outlined in Policy CC.COMP.22, Policy Management.

Staffing is sufficient to ensure that health care services required by the State of Mississippi are provided to members. The relationships among staff are clearly outlined in the Organizational Chart and supplemental documents.

The Information Systems Capabilities Assessment (ISCA) documentation provided by Magnolia indicates the organization is capable of satisfying the IT requirements of the State contract. Notably, the organization's resiliency strategies address its diverse infrastructure that is comprised of both cloud and traditional data centers. Additionally, Magnolia exceeds the State's timeliness requirements by averaging greater than 99% of clean claims being paid in 30 days and 100% being paid in 90 days. Finally, Magnolia's security plan ensures data is protected both physically and technically.

Magnolia's Policy CC.COMP.16, Fraud, Waste, and Abuse Plan and Addendum M outlines that a Fraud, Waste, and Abuse (FWA) training program is administered in conjunction with Centene's Ethics and Compliance training annually and at new hire orientation. The training is mandatory for all employees, including officers, directors, and managers. The Centene Business Ethics and Code of Conduct indicates that all employees and Board members are also required to read the Business Ethics and Code of Conduct annually.

Led by the Compliance Officer, the Compliance Committee Charter states that, "The Compliance Committee consists of a cross-functional team that is responsible to provide Magnolia with feedback and to make recommendations regarding health plan compliance

issues. This Committee reports directly to the BOD." A toll-free hotline number has been established to report potential FWA activities. The hotline is operated by an independent third party and all referrals are sent directly to a member of the Special Investigative Unit management and analyst team. A FWA email is available for the reporting of suspected fraud.

Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414

Appropriate processes are in place for initial credentialing and recredentialing of providers for participation in the network. A sample of initial credentialing files and recredentialing files were reviewed for independent practitioners and organizational providers. Only one issue was identified: the absence of the collaborative agreement between one nurse practitioner and the supervising physician. Site visits are on hold due to the COVID-19 pandemic. Magnolia reported that a list of providers is being maintained and the site visits will be completed when restrictions are lifted.

Providers who meet established criteria with no identified issues are reviewed and approved by the Medical Director. The Credentialing Committee, comprised of network practitioners and health plan staff, uses a peer review process to issue credentialing decisions for providers who require Level II review. Several voting practitioner members do not meet the attendance expectation for the Credentialing Committee

Magnolia routinely monitors the type, number, geographic distribution of primary care providers (PCPs), specialty providers, and other provider types within its network using contractually compliant parameters. Magnolia's goal for the percentage of members with the required access to PCPs and non-PCP providers is 90%. Data considered in assessments of network adequacy include Geo Access mapping; member satisfaction with practitioner access and availability; complaint and grievance data; and cultural, ethnic, racial, and linguistic needs of the membership. Results are analyzed and recommendations are developed and implemented to address any identified deficiencies in network adequacy.

Appropriate processes are in place for initial and ongoing provider education. The Provider Manual is a resource for providers and includes information necessary to understand Magnolia's programs, requirements, and member benefits. A recommendation was made to revise the Provider Manual to include restrictions on a PCP's ability to request reassignment of a member to another PCP.

Magnolia's printed and searchable web-based Provider Directory include all required elements. Some provider entries in the directory indicate details about accommodations for people with physical disabilities are pending. Discussion revealed a corporate initiative to gather and include this information was in progress but has been delayed by the COVID-19 pandemic. Routine usability testing of the web-based Provider Directory is

conducted through the Member Advisory Committee or by random survey, conducted on an ad hoc basis and after any upgrades to functionality or design.

Preventive health and clinical practice guidelines are adopted from recognized sources and are relevant to the member population. The guidelines are reviewed and updated at least annually and when there is significant new scientific evidence or changes in national standards. Board-certified practitioners provide input on the guidelines through the Quality Committee.

Providers are informed of medical record documentation standards and are assessed for compliance to those standards annually through a medical record review process. Results are trended by the Quality Improvement (QI) Department to determine plan-wide areas in need of improvement and may be addressed via network-wide and/or provider-specific education. Results are also considered at recredentialing.

Magnolia's Cultural Competency Plan (CCP) describes activities to ensure the health plan and its provider network meet members' linguistic and cultural needs. Activities include providing cultural competency training to subcontractors and network providers quarterly and including information in the Provider Manual and on Magnolia's website. Magnolia conducts an annual evaluation of the effectiveness of the CCP. Any identified issues are tracked and trended, and interventions to improve the provision of services are implemented.

The 2020 Provider Satisfaction Survey was conducted by SPH Analytics. The low response rate may affect the generalizability of the findings. No survey measures had a significant decline, and six measures had a significant increase. To ensure a greater representation of the provider population in the satisfaction surveys, CCME recommends that Magnolia analyze barriers to survey responses and implement actions to address those barriers.

Member Services

42 CFR § 438.56, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR § 438.3 (j), 42 CFR § 438.228, 42 CFR § 438, Subpart F

Magnolia's member rights and responsibilities are outlined in Policy MS.MBRS.25, Member Rights and Responsibilities, the Member Handbook, Provider Manual, and on Magnolia's website. Policy edits were made to reflect all contract-specific rights and responsibilities.

New member packets are described in Policy MS.MBRS.01, New Member Packet/Member ID card and Policy MS.MBRS.02, Member Handbook. Members are provided a New Member Packet within 14 days after Magnolia receives the member's enrollment data from DOM. The Provider Directory is made available electronically on the Magnolia website and a printed version is available upon request. Limits of coverage, maximum allowable benefits, and no cost services are outlined in the Member Handbook. Policies and

procedures are in place outlining steps to be taken for member enrollment and disenrollment.

Members are provided with a toll-free access number, an automated voice system, or a live person to address questions or concerns. Policy MS.MBRS.10, Member Service Calls/Hotline, and MS.PRVR.03, Toll-free Provider Telephone Hotline, state Magnolia maintains a toll-free Member Services and Provider Services call center as required. The 24-Hour Nurse Advice Line is available 24 hours a day, seven days a week, including holidays. Call Center hours of operation are consistently identified on the Magnolia website, in the Member Handbook, and in the Provider Manual. Call Center agents have appropriate call scripts and work processes to assist members and providers, such as scripts for Member Returning Calls, Handling Behavioral Health Crisis Calls, Provider Services Escalation, and Pharmacy Calls. Training is mandated upon hire and at least quarterly and records of the training are maintained. Incoming and outgoing call activity is audited and monitored, and recorded calls are used as training tools for quality improvement efforts.

Magnolia ensures the provision of screening, preventive, and medically necessary diagnostic and treatment services for members through the month of their 21st birthday, as stated in Policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Service, and Policy MS.QI.20.01, EPSDT Notification System. Policies describe processes and methods for notification, tracking, and follow-up of the EPSDT services and address barriers for low utilization by creating interventions to encourage members to use the services.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are conducted annually via a third-party vendor, SPH Analytics. The MY2020 survey response rates continue to fall below the National Committee for Quality Assurance (NCQA) target response rate of 40%.

Grievance terminology is defined and filing processes are outlined in Policy MS.MBRS.07, Member Grievance and Complaints Process, the Member Handbook, the Provider Manual, and on Magnolia's website. Grievances are acknowledged in writing within five calendar days. Information for filing by an Authorized Representative was referenced in policy and on Magnolia's website. Of the randomly selected grievance files submitted for the 2021 EQR, there were no identified patterns of noncompliance with the receipt, acknowledgement, investigation, and resolution notifications.

Quality Improvement

42 CFR §438.330, and 42 CFR Part 441, Subpart B

Magnolia provided the 2021 MississippiCAN Quality Management Program Description. This QI Program Description included the program objectives or priorities and goals and the

program's structure and scope. The QI Program Description describes Magnolia's efforts to reduce health disparities through their Cultural Competency Program. Magnolia also assesses and identifies interventions to address health disparities at a statewide and regional level.

Magnolia's Board of Directors has authority, responsibility, and oversight of the development, implementation, and evaluation of the QI Program. The Board is responsible for evaluating the QI Program Description and the Quality Work Plan to assess whether program objectives were met and to recommend adjustments when necessary.

Magnolia develops a QI Work Plan annually after completing the Quality Program Evaluation for the previous year. The 2020 and 2021 QI Work Plans were provided for review. Both Work Plans included all ongoing QI activities, the responsible party, and target or completion dates. The Work Plan is presented to the Quality Improvement Committee (QIC) at least annually for review and approval.

The Board delegates the operating authority of the QI Program to the QIC. Magnolia's senior management staff, clinical staff, and network practitioners serve on the QIC and are involved in the implementation, monitoring, and direction of the relative aspects of the QI Program. The Chief Medical Director chairs the QIC. Voting members include Magnolia's senior leaders, representing all departments of the organization and five network providers. Their specialties include Pediatrics, Family Practice, Psychiatry, and a family nurse practitioner.

Magnolia provides coverage for a full range of EPSDT services as required by the DOM contract. Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service, describes the process Magnolia uses to monitor compliance with the EPSDT program requirements and initiate interventions to improve compliance for providers and members. Per Policy MS.QI.20, Magnolia's EPSDT Coordinator will monitor claims to identify members with any abnormal finding on an EPSDT screening. If there is no evidence that treatment was sought, the EPSDT Coordinator will contact the provider and member to assist in arranging an appointment for follow-up.

During the previous EQR, CCME issued a Recommendation that Magnolia update the EPSDT tracking report to identify members needing follow-up care after an EPSDT screening and include the CPT codes and dates or notes regarding the contact made. The sample EPSDT tracking report provided for this EQR showed evidence this Recommendation was implemented.

Magnolia's Mississippi Coordinated Access Network (MSCAN) Quality Management Program Evaluation 2020 summarizes the completed and ongoing QI activities and evaluates the overall effectiveness of the program. The 2020 QI Program Evaluation covers activities

completed between January 1, 2020, and December 31, 2020. Overall, there were no issues found for the QI Program Evaluation.

Performance Measure Validation

42 CFR §438.330 (c)

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the Performance Measures (PMs) identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population. PM validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted the validation following the CMS-developed protocol for validating PMs. The final PM validation results reflected the measurement period of January 1, 2020, through December 31, 2020.

Aqurate reviewed the CCOs' final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Magnolia . Aqurate found that Magnolia's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2020. During the audit process, Magnolia's HEDIS auditor noted that Magnolia needed to improve its processes for providing data for various audit steps in a timely manner to avoid the risk of missing critical NCQA deadlines.

All relevant HEDIS PMs for the CAN population were compared for the current review year (MY 2020) to the previous year (MY 2019) and the changes from 2019 to 2020 are reported in the QI section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have a substantial increase or decrease in rate from 2019 to 2020. A substantial increase or decrease is a change in rate of greater than 10%. For HEDIS MY 2020, there were no measure rates that had a greater than 10% improvement. However, given the difficulties due to the COVID-19 pandemic, there were very few measures that showed a greater than 10% decline.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2019	Measure Year 2020	Change from 2019 to 2020
Substantial Decrease in Rate (>10% improvement)			
Adult BMI Assessment (aba)	78.59%	40.58%	-38.01%
Annual Dental Visit (adv)			
2-3 Years	56.15%	41.82%	-14.33%
4-6 Years	76.79%	61.08%	-15.71%

Measure/Data Element	Measure Year 2019	Measure Year 2020	Change from 2019 to 2020
7-10 Years	77.86%	62.82%	-15.04%
11-14 Years	73.63%	61.27%	-12.36%
Total	71.08%	57.72%	-13.36%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. Aqurate conducted additional source code review, medical record review validation, and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Aqurate found Magnolia was compliant with data integration, data control, and documentation of PM calculations. Magnolia did not report the Sealant Receipt On Permanent First Molars (SFM-CH) measure as required by DOM.

The HEDIS and non-HEDIS measure rates for the CAN populations reported by Magnolia for 2020 are listed in the QI section of this report.

Performance Improvement Project Validation

42 CFR §438.330 (d)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

DOM requires the CCOs to conduct PIPs that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child - Asthma and Adult - COPD).

For the previous EQR (2020), Magnolia submitted four PIPs for validation that addressed the DOM-required topics. All four PIPS scored in the "High Confidence in Reported Results" range and met the validation requirements. CCME provided Recommendations regarding the documented, quantitative improvements in processes, or outcomes of care presentation in the PIP documents. For the current EQR, Magnolia provided four PIP documents for validation. It was noted that the Improving Pregnancy Outcomes with Makena PIP was retired, and the Reducing Preterm Births PIP was submitted. All the PIPs scored in the "High Confidence in Reported Results" range, as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

Table 2: Behavioral Health Readmissions PIP

Behavioral Health Readmissions	
The Behavioral Health Readmissions PIP aimed at reducing the 30-day psychiatric readmission rates in Hinds County, Brentwood, and MS State Hospital. For this validation, the PIP showed an increase in the readmission rate (2020 annual rate) to 27.69% from the previous year's rate of 13.05% This was a substantial increase in the readmission. Magnolia felt the increase was due to a decrease in the total number of admissions and unable to contact members. Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Behavioral Health Care Management Team to provide education and support services to promote adherence to treatment plans, assist with scheduling appointments, and enrolling the member in the care management program. The Clinical Provider Trainer will continue to conduct both telephonic and face-to-face visits with all Hinds County Behavioral Health facilities to provide education and resources to aide in the discharge planning process, address any barriers identified in the discharge planning process, and assist with resolving any other identified issues.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Telephonic outreach by the Clinical Provider Trainer for Behavioral Health to all Hinds County Behavioral Health facilities to provide education, resources, and address any barriers. • Direct outreach to members discharged from Hinds County Behavioral Health facilities by the Behavioral Health Team to complete the TOC Assessment.	

Table 3: Reducing Preterm Births PIP

Reducing Preterm Births	
The Reducing Preterm Births PIP is a newly initiated PIP with baseline data only. Th goal for this PIP is to reduce the preterm birth rate by interventions directed at members with hypertension or pre-eclampsia. The baseline rate was 13.4% with a benchmark of 11.4%.	
Previous Validation Score	**Current Validation Score**
N/A	70/70=100% High Confidence in Reported Results
Interventions	
• Completing Notification of Pregnancy (NOP) as applicable • Enrolling member in the Start Smart for Baby program • Refer to Care Management for continuous follow up • Identify various methodologies to enhance patient education and engagement to increase early intervention. Develop materials on controlling hypertension during pregnancy and distribute to members as needed. • Develop a plan and criteria to distribute blood pressure cuffs to member	

Table 4: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
The goal of the Sickle Cell Disease Outcomes PIP is to increase the compliance rate of Hydroxyurea for members who are prescribed to take the medication. Magnolia did not meet the goal that 47% of members with a diagnosis of Sickle Cell Disease who were dispensed a prescription for Hydroxyurea and remained on the medication during the treatment period. Results for 2019 were recorded at 35.5%, 34.7% in 2020 and 20.6% in 2021. Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Pharmacy Team to provide education on the importance of medication adherence, assess for potential barriers or concerns, provide education on 90-day fills and convert more prescriptions to 90-day fills, assist with medication refills as needed, and refer to Care Management as needed. The Pharmacy Team will also continue mailing letters to the Providers of members identified as having a new diagnosis of Sickle Cell or a new prescription for Hydroxyurea quarterly to promote collaboration and medication adherence.	
Previous Validation Score	**Current Validation Score**
73/74= 99% High Confidence in Reported Results	73/74= 99% High Confidence in Reported Results
Interventions	
• Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and also on the importance of medication adherence. • Pharmacy Team mailed letters to the Providers of those members identified, encouraging the Provider to discuss medication adherence at the member's next scheduled appointment. • Pharmacy Team outreached all members who received letters to provide education and to address any barriers/concerns. • Referrals to Care Management as needed.	

Table 5: Asthma/COPD PIP

Asthma/COPD	
The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year. This indicator uses the HEDIS measures Asthma Medication Ratio (AMR). A decrease in percentile range was noted from baseline (71.15%) to remeasurement period 1 (70.24%) with a goal of 76.86%. For the adult population, this PIP measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. This indicator uses the HEDIS measure, Use of Spirometry testing in the Assessment and Diagnosis of COPD (SPR). A decrease in percentile range was noted from baseline (28.38%) to remeasurement period 1 (26.49%) with a goal of 36.82%. Magnolia did not achieve the goal for either study indicator. Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Population Health Management Team to provide education, offer support services and enrollment into the care management program, Provider education via E-blast, and member/Provider outreach by the Pharmacy Team.	
Previous Validation Score	**Current Validation Score**

Asthma/COPD	
80/80=100% High Confidence in Reported Results	73/74= 99% High Confidence in Reported Results
Interventions	
• Direct outreach by the Population Health Management Team to non-compliant members identified in both the Asthma Medication Ratio (AMR) and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations. • Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population. • Education on the AMR & SPR measures in provider newsletters by the Quality Improvement Team.	

Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 208, 42 CFR § 208

CCME's assessment of Magnolia's Utilization Management (UM) Program included reviews of the Utilization Management Program Description 2021, program evaluations, policies, member and provider materials, the health plan's website, and approval, denial, appeal, and case management files. The UM Program Description describes and defines collaboration between the UM Program with other programs within the Population Health and Clinical Operations Department. Policies and procedures are well-written and clearly define how services are implemented and provided to members.

Magnolia's Medical Director and the Vice President of Population Health and Clinical Operations provide oversight and expertise for UM activities. Appropriate reviewers conduct service authorization requests using InterQual criteria or other established criteria. The review of approval and denial files provided evidence that appropriate processes are followed, and no major issues were identified. The review of appeals files revealed staff consistently follow processes outlined for handling appeals of adverse benefit determinations. The Care Management (CM) policies appropriately document CM processes and services provided. CM files indicated care gaps are identified and addressed consistently, and services are provided for various risk levels.

Overall, no weaknesses were identified for the UM Program. Areas of strength include, but are not limited to, well-written policies, detailed analysis of UM activities in the UM Program Evaluation and conducting a COVID-19 project that includes outreach to all members.

Delegation

42 CFR § 438.230

Processes for delegation, annual oversight, and ongoing monitoring are documented in policy. Prior to implementing a delegation agreement, Magnolia assesses the potential

delegate's ability to conduct the delegated activities and services in accordance with State, NCQA, and/or other external requirements. For each of its delegated entities, Magnolia presented delegation agreements that specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.

Magnolia retains accountability for each delegated service and monitors the performance of the delegated entity. A formal, annual assessment is conducted of each delegated entity to determine whether delegated activities are being carried out as required. Evidence of preassessment activities, annual oversight, and ongoing monitoring were provided for each of Magnolia's delegates. Tools used in the monitoring and oversight include appropriate elements for each of the services delegated. Reports of the monitoring and oversight included documentation of any deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan.

Quality Improvement Plans and Recommendations from Previous EQR

For the previous EQR, there were eight standards scored as "Partially Met." The following is a high-level summary of those deficiencies:

- Initial credentialing and recredentialing provider files were missing some required elements.
- The Member Rights and Responsibilities policy did not include all member rights and responsibilities.
- The Provider Manual incorrectly listed hours of operation.
- The Member Grievance and Complaints Process policy did not specify that grievance records will be retained "during the entire term of the Contract and for a period of 10 years thereafter," as noted in the *CAN Contract, Section 11 (A)*.
- Issues were identified with appeals documentation related to use of outdated terminology and incomplete information about who can act as a member's authorized representative.

After the 2020 EQR, Magnolia submitted its response to the Corrective Action Plan (CAP) on January 22, 2021. The CAP was accepted on February 2, 2021. A follow-up review of the CAP was initiated on April 1, 2021 and completed on April 27, 2021. During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found Magnolia implemented all of the items in the CAP.

II. Conclusions

Overall, Magnolia met the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. The 2021 Annual EQR shows that Magnolia achieved a "Met" score for 99.5% of the standards reviewed. As the following chart indicates, 0.5% of the standards were scored as "Partially Met."

Figure 1: 2021 Annual EQR Review Results for CAN

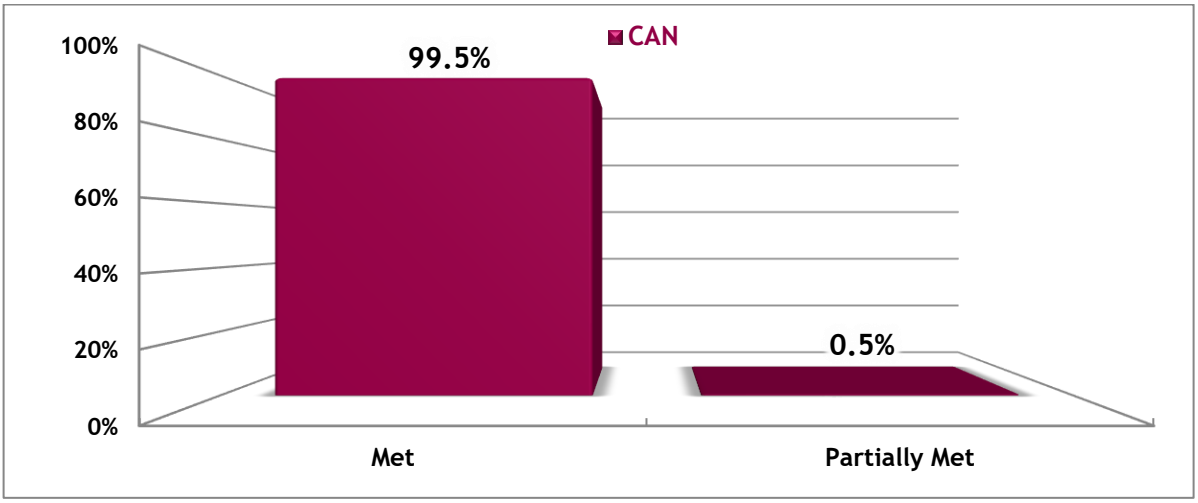


Table 6: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review. For 2021, 223 out of 224 standards received a score of "Met." There was one standard scored as "Partially Met."

Table 6: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2020	31	0	0	0	0	31	100%
2021	31	0	0	0	0	31	100%
Provider Services							
2020	83	3	0	0	0	86	96.5%
2021	83	1	0	0	0	84	98.8%
Member Services							
2020	29	4	0	0	0	33	87.9%
2021	33	0	0	0	0	33	100%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Quality Improvement							
2020	19	0	0	0	0	19	100%
2021	19	0	0	0	0	19	100%
Utilization Management							
2020	53	1	0	0	0	54	98.1%
2021	55	0	0	0	0	55	100%
Delegation							
2020	2	0	0	0	0	2	100%
2021	2	0	0	0	0	2	100%
Totals							
2020	217	8	0	0	0	225	96%
2021	223	1	0	0	0	224	99.5%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Table 7: Compliance Review Results for Part 438 Subpart D and QAPI Standards provides an overall snapshot of Magnolia's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

Table 7: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Number of CAN Standards	Number of CAN Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	9	9	100%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	18	18	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	38	37	97%
• Confidentiality *(§ 438.224)*	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	20	20	100%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	2	2	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	11	11	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	4	4	100%

Category	Number of CAN Standards	Number of CAN Standards Scored as "Met"	Overall Score
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	18	18	100%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

The following tables provide an overview of strengths, weaknesses, and recommendations related to the quality, timeliness, and access to care identified during this annual review of Magnolia.

Table 8: Evaluation of Quality

Strengths Related to Quality
• Magnolia continues to employ alternate methods to ensure ongoing provider education while under restrictions related to COVID-19. • Policy MS.MBRS.25, Member Rights and Responsibilities, was revised to include all member rights and responsibilities. • Guidelines for clinical practice and preventive care that are relevant to the member population are adopted with input from network practitioners. • Providers are educated about medical record documentation standards and assessed for compliance. Results are used for quality improvement and considered at recredentialing. • Magnolia tracks EPSTD services and monitors claims to identify members with abnormal findings and assists with follow-up as needed. • Magnolia was fully compliant with all information systems standards and submitted valid and reportable rates for all HEDIS measures in scope of this audit. • There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Magnolia followed the measure specifications and produced reportable rates for most measures in the scope of the validation. • Appeal policies are well-written. The purpose is clearly stated, procedures steps are detailed and divided into appropriate sub-categories, and applicable definitions and a log of revisions are included. • The UM Program Evaluation includes detailed analysis of UM activities and outcomes and provides insight to barriers and interventions to address them. • The appeal files submitted for review were well organized and included all pertinent information. • Magnolia is conducting a COVID-19 project that includes outreach and education to all plan members. • Delegation agreements are in place with each delegated vendor and specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations. • Monitoring and oversight tools include appropriate elements for each of the services delegated.

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
• The Credentialing Committee charter indicates the attendance expectation is 75% of scheduled meetings; however, of the 11 meetings reviewed, one provider attended only 45% of the meetings. This provider was also noted to have	• Recommendation: Reinforce Credentialing Committee attendance expectations with committee members and take necessary steps to replace or remove members who do not meet the attendance expectations.

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
poor attendance during the previous EQR. Two additional providers attended only 64% of the meetings.	
• One nurse practitioner file did not include the full collaborative agreement between the nurse practitioner and the supervising physician.	• Corrective Action: Ensure credentialing files contain the complete collaborative agreement for nurse practitioners.
• The Provider Manual does not list restrictions on a PCP's ability to request reassignment of a member to another PCP.	• Recommendation: Include all pertinent information about PCP requests to reassign members to another PCP, including circumstances for when this is inappropriate, in the Provider Manual.
• Magnolia's Provider Manual directs the reader to the website for a full list of preventive health guidelines. However, the link in the Provider Manual is incorrect and takes the user to a page that only says "Error."	• Recommendation: Revise the Provider Manual to include the correct URL for the preventive health guidelines on Magnolia's website.
• The total sample size for the Provider Satisfaction Survey was 2000, and 183 providers responded for a 9.2% response rate. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings.	• Recommendation: Analysis of barriers to gathering Provider Satisfaction Survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the provider PCP, Specialist, and Behavioral Health population on the satisfaction surveys.
• The Behavioral Health Readmissions, Sickle Cell Disease Outcomes and the Asthma COPD PIPs demonstrated no quantitative improvement in process or care.	• Recommendation: Continue working on provider and member interventions for the performance improvement projects that demonstrated no quantitative improvements in process or care.
• Magnolia did not report the Sealant Receipt on Permanent First Molars (SFM-CH) non-HEDIS measure as required by DOM.	• Recommendation: Magnolia should work proactively with DOM for clarification on non-HEDIS measures that are required to be reported.
• During the audit process it was noted by Magnolia's HEDIS auditor that Magnolia needed to improve its processes for providing data for various audit steps in a timely manner to avoid the risk of missing critical NCQA deadlines.	• Recommendation: Based on Magnolia's HEDIS auditor's findings in the Final Audit report, it is recommended that Magnolia improve the processes for providing data for various audit steps in a timely manner.
• Magnolia was unable to provide responses for rate comparison concerns effectively.	• Recommendation: Improve processes around calculation, reporting and verification of the rates reported for the DOM required Adult and Child Core set measures.

Table 9: Evaluation of Timeliness

Strengths Related to Timeliness
• Policies are managed in a timely manner to ensure that reviews and revisions occur in advance of the due date by applicable department leaders and the business department.
• The Provider Manual was revised to reflect the Provider Services hours of operation are 7:30 am to 5:30 pm CST.

Strengths Related to Timeliness
• Clean claim payment rates that meet and exceed the State requirements.

Table 10: Evaluation of Access to Care

Strengths Related to Access to Care	
• Adequacy of the provider network and compliance with appoint access standards are routinely monitored. Parameters used for monitoring are compliant with contractual requirements.	
Weaknesses Related to Access to Care	**Corrective Actions / Recommendations Related to Access to Care**
• Regarding verification of member eligibility, the Magnolia website states, "Eligibility can be verified through:" but does not provide any information.	• Recommendation: Revise the Magnolia website to include the methods available for verifying member eligibility.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally-mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On July 6, 2021, CCME sent notification of the initiation of the annual EQR to Magnolia (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN Program.

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with CCME and DOM for purposes of providing Magnolia an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials CCME requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on August 4, 2021, for review at the CCME offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on October 18, 2021, and October 19, 2021. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Magnolia administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*, and the Contract requirements between Magnolia and DOM. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4).

I. Administration

42 CFR § 438.242, 42 CFR § 438.224

Magnolia manages policies using the RSA Archer® system for tracking and review notification purposes. Policies are applicable to all employees of Centene Corporation, its

affiliates, and subsidiaries. Guidance for the development, review, approval, and maintenance of policies is outlined in Policy CC.COMP.22, Policy Management.

Staffing is sufficient to ensure that health care services required by the State of Mississippi are provided to members. The relationships among staff are clearly outlined in the Organizational Chart and supplemental documents.

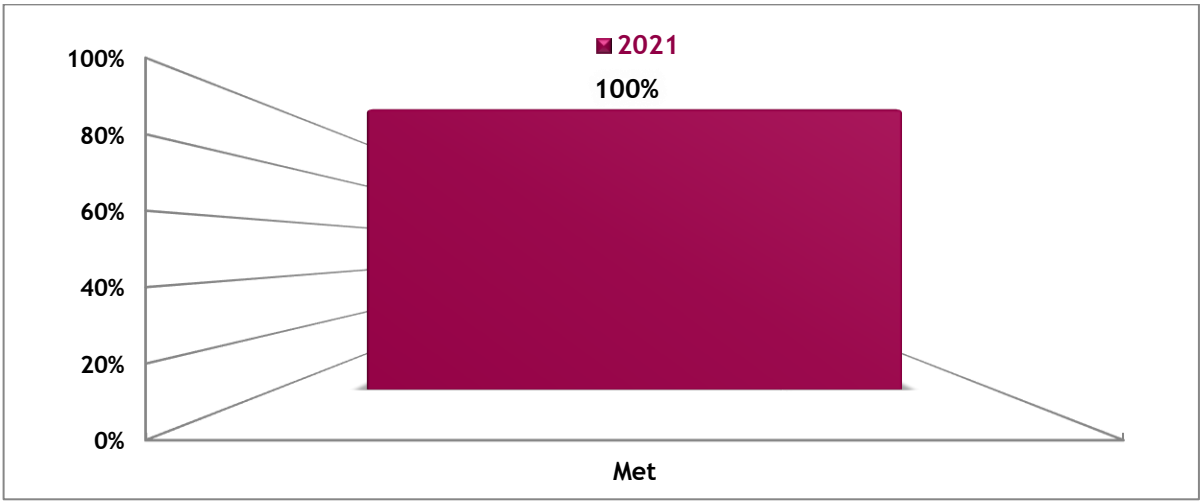
The Information System Capabilities Assessment (ISCA) documentation provided by Magnolia indicates the organization is capable of satisfying the IT requirements of the State contract. Notably, the organization's resiliency strategies address its diverse infrastructure that is comprised of both cloud and traditional data centers. Additionally, Magnolia exceeds the State's timeliness requirements by averaging greater than 99% of clean claims paid within 30 days, and 100% paid within 90 days. Lastly, Magnolia's security plan ensures data is protected both physically and technically.

Policy CC.COMP.16, Fraud, Waste, and Abuse Plan, and Addendum M indicate that a Fraud, Waste, and Abuse (FWA) training program is administered in conjunction with Centene's Ethics and Compliance training annually and at new hire orientation. The training is mandatory for all employees, including officers, directors, and managers. The Centene Business Ethics and Code of Conduct indicates all employees and Board members are also required to read the Business Ethics and Code of Conduct on an annual basis.

Led by the Compliance Officer, the Compliance Committee has responsibilities identified in the Compliance Committee Charter. The Charter states, "The Compliance Committee consists of a cross-functional team that is responsible to provide Magnolia with feedback and to make recommendations regarding health plan compliance issues. This Committee reports directly to the BOD." A toll-free hotline number is established to report potential FWA activities. The hotline is operated by an independent third party, and all referrals are sent directly to a member of the Special Investigative Unit management and analyst team. A FWA email inbox is available for reporting suspected fraud.

In the Administration section of the review, Magnolia received "Met" scores for 100% of the standards reviewed, as illustrated in *Figure 2: Administration Findings*.

Figure 2: Administration Findings



Strengths

- Policies are managed in a timely manner to ensure that reviews and revisions occur in advance of the due date by applicable department leaders and the business department.
- Clean claim payment rates that meet and exceed the State requirements.

II. Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414

The review for Provider Services focused on policies and procedures, provider training and educational materials, the provider network, credentialing and recredentialing processes and files, practice guidelines, and the provider satisfaction survey.

Provider Credentialing and Selection

42 CFR § 438.214

For initial credentialing and recredentialing, providers who meet established criteria are reviewed and approved by a medical director or designated physician. The Credentialing Committee provides advice and expertise for credentialing decisions and reviews credentials for providers who do not meet established thresholds using a peer-review process. Magnolia's Credentialing Committee is comprised of network practitioners and health plan staff and is chaired by the Medical Director. The quorum is established as the presence of 50% of the voting members, and the Medical Director and network physician attendees are considered voting members.

The Credentialing Committee charter indicates the attendance expectation is 75% of scheduled meetings. Onsite discussion confirmed that if a committee member does not

meet the attendance requirement, the health plan engages with the committee member to discuss the attendance expectations and will take action to replace or remove the member, if necessary. Review of the submitted Credentialing Committee minutes revealed that of the 11 meetings reviewed, one practitioner attended only 45% of the meetings, and two additional practitioners attended only 64% of the meetings. The provider who attended only 45% of the meetings was also noted to have poor attendance during the previous EQR. CCME recommends that Magnolia reinforce Credentialing Committee attendance expectations with committee members and take necessary steps to replace or remove members who do not meet the attendance expectations.

Processes and requirements for credentialing and recredentialing activities for independent practitioners and organizational providers are found in several policies and procedures as well as in the Credentialing Program Description. Samples of initial credentialing and recredentialing files were reviewed for independent practitioners and organizational providers. An issue was discovered in only one file: the initial credentialing file for a nurse practitioner was missing the collaborative agreement between the nurse practitioner and the supervising physician and included only a print-out from the Mississippi Board of Nursing Licensee Gateway. No issues were identified in the initial credentialing and recredentialing files for organizational providers.

Magnolia reported that site visits are not currently being conducted due to restrictions from the COVID-19 pandemic. However, a list of providers is being maintained and the site visits will be completed when restrictions are lifted.

Magnolia has established processes and mechanisms for ongoing monitoring of quality and safety of practitioner services, as described in Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting. After an investigation is conducted, the Credentialing Committee is responsible for deciding if a provider's participation should be suspended, restricted, or terminated. Processes for implementing a provider termination are appropriately addressed in Policy MS.PRVR.23, Provider Termination.

The current EQR confirms that issues identified during the 2020 EQR were corrected. See *Table 11: Previous Provider Credentialing and Selection CAP Items*. Although DOM advised the CCOs that they are no longer required to collect Ownership Disclosure Forms for credentialing and recredentialing, Magnolia has continued to include them in credentialing and recredentialing files.

Table 11: Previous Credentialing and Selection CAP Items

Standard	EQR Comments
II A. Credentialing and Recredentialing	
3.1 Verification of information on the applicant, including: 3.1.15 Ownership Disclosure form.	Three initial credentialing files were missing a copy of the Ownership Disclosure Form. An additional five files contained outdated Ownership Disclosure Forms with signatures dated up to four years prior to the credentialing decision. During onsite discussion, credentialing staff reported that at the time of credentialing, Ownership Disclosure Forms must have been signed within 12-14 months of the credentialing event. *Corrective Action: Ensure all credentialing files include an Ownership Disclosure Form and that signature dates are current.*
Magnolia's response: Health Plan team will ensure that all enrollments, including those submitted via roster include an Ownership and Disclosure form with current signature dates. Staff have received refresher training and the Credentialing application checklist has been updated to reflect that the Ownership and disclosure form must be signed within 12-14 months.	
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies. 4.2.14 Ownership Disclosure form.	The Ownership Disclosure Forms in two recredentialing files were outdated, with signatures dates as old as four years prior to the credentialing decision date. *Corrective Action: Ensure all Ownership Disclosure Forms are current.*
Magnolia's response: The Re-credentialing team will ensure that all Ownership and Disclosure forms are current. Team will receive a refresher training regarding these items to be completed no later than February 15, 2020.	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	Policy CC.CRED.09, Organizational Assessment and Reassessment defines processes for ensuring all institutional providers are accredited and/or licensed according to applicable state and federal regulations and applicable standards of accrediting bodies, such as the National Committee for Quality Assurance (NCQA). The following issues were noted in the organizational provider recredentialing files: •One provider's license was expired at the time of recredentialing. The license expired on March 31, 2020, and primary source verification and committee approval for this provider occurred on April 14, 2020. •Two files contained unsigned Ownership Disclosure Forms. *Corrective Action: Ensure all recredentialing files for organizational providers have evidence of current, unexpired licensure, and that all Ownership Disclosure Forms are signed.*
Magnolia's response: Organizational Re-credentialing Team will ensure that all re-credentialing files for organizational providers have evidence of current, unexpired licensure, and that all Disclosure of Ownership forms are signed. Team will receive a refresher training regarding these items to be completed no later than February 15, 2020.	

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.207

Mechanisms used by Magnolia's Provider Relations Department for monitoring the type, number, and geographic distribution of primary care providers (PCPs), specialty providers, and other provider types are found in Policy CC.PRVR.47, Evaluation of Practitioner Availability. Standards for geographic access to PCPs, high-volume specialists, and prescribing and non-prescribing behavioral health practitioners are listed in a table within the policy and are compliant with contractual requirements. Magnolia's goal for the percentage of members with the required access to PCPs and non-PCP providers is 90%. The Geo Access report dated July 19, 2021, confirms correct parameters were used for measuring access to PCPs, specialists, and other providers.

Annual measurements of practitioner types and availability are conducted via Geo Access mapping. Magnolia also measures appointment accessibility to primary care services, behavioral health services, and specialty care services annually, as noted in Policy CC.PRVR.48, Evaluation of the Accessibility of Services. Other data considered in assessments of network adequacy include member satisfaction with practitioner access and availability; complaint and grievance data; cultural, ethnic, racial, and linguistic needs of the membership; etc. Results are reported and reviewed by the Quality Committee, analyzed, and recommendations are developed and implemented to address any identified deficiencies in the number, distribution, or type of practitioners available to Magnolia's membership.

Magnolia provides a current PCP Panel/Patient List to all participating PCPs via its secure provider web portal, which is updated within five business days of receiving the monthly enrollment file from DOM. Providers may also call the Provider Services Call Center to verify their member panel and member eligibility. Both participating and non-participating providers can verify enrollment by telephone, the interactive voice response system, contacting a Provider Services Representative, and via the Mississippi Envision Web Portal. All these methods of verifying eligibility are documented in the Provider Manual. The Magnolia website includes a page to describe methods of verifying member eligibility; however, the information is missing.

A written Cultural Competency Plan is in place and describes activities and mechanisms to ensure the health plan and its provider network meet members' linguistic and cultural needs. Provider-facing activities include providing cultural competency training to subcontractors and network providers quarterly and including information about cultural competency in the Provider Manual and on Magnolia's website. Magnolia conducts an annual evaluation of the effectiveness of the Cultural Competency Plan. Any identified issues are tracked and trended, and interventions to improve the provision of services are implemented.

Provider Education

42 CFR § 438.414

Providers are informed of medical record documentation standards and are assessed for compliance to those standards annually through a medical record review process. Written notification of results is mailed to the provider within 15 days, including the overall score, areas of deficiency, a copy of the completed/scored audit tool, and an action plan for improvement, if necessary. A follow-up audit is conducted within six months for overall scores below 90%. Results are trended by the Quality Improvement (QI) Department to determine areas in need of improvement and may be addressed via network-wide or provider-specific education. Results are considered at recredentialing.

Provider Satisfaction Survey Validation

SPH Analytics conducted the 2020 Provider Satisfaction Survey. Of a total sample size of 2000, 183 providers responded yielding a 9.2% response rate. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.1% (51 out of 282).

No survey measures had a significant decline, and six measures had a significant increase: rating of health plan, access to knowledgeable Utilization Management staff, procedures for precertification, timeliness for precertification, health plan's facilitation for clinical care for patients, and ease of prescribing preferred medications.

To ensure a greater representation of PCPs, specialists, and behavioral health providers in the satisfaction surveys, it is recommended that Magnolia analyze barriers to gathering survey responses and implement actions to address those barriers.

The table below offers the section of the Provider Satisfaction Survey Validation worksheet that needs improvement, the reason, and the recommendation.

Table 12: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The total sample size was 2000 and 183 responded for a 9.2% response rate. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.1% (51 out of 282).	Analysis of barriers to gathering survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the PCP, specialist, and behavioral health provider population on the satisfaction surveys.

As noted in *Figure 3, Provider Services Findings*, Magnolia received "Met" scores for 98.8% of the Provider Services standards.

Figure 3: Provider Services Findings

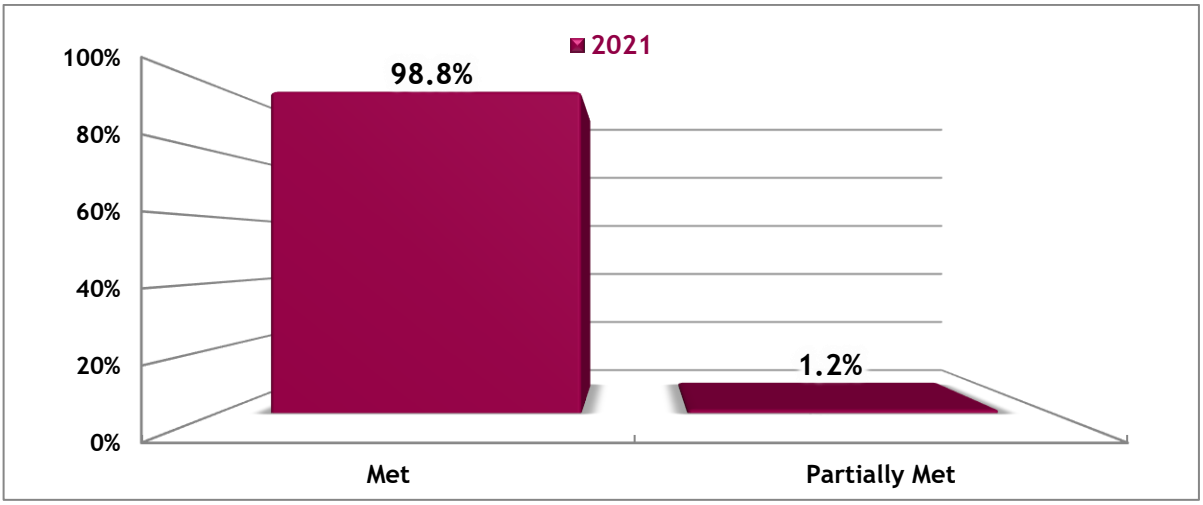


Table 13: Provider Services

Section	Standard	CAN 2020 Review	CAN 2021 Review
Credentialing and Recredentialing	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Partially Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021

Strengths

- The adequacy of the provider network and compliance with appoint access standards are routinely monitored. Parameters used for monitoring are compliant with contractual requirements.
- Magnolia continues to employ alternate methods to ensure ongoing provider education while under restrictions related to COVID-19.
- Guidelines for clinical practice and preventive care that are relevant to the member population are adopted with input from network practitioners.
- Providers are educated about medical record documentation standards and assessed for compliance. Results are used for quality improvement and considered at recredentialing.

Weaknesses

- The Credentialing Committee charter indicates the attendance expectation is 75% of scheduled meetings; however, of the 11 meetings reviewed, one provider attended only 45% of the meetings. This provider was also noted to have poor attendance during the previous EQR. Two additional providers attended only 64% of the meetings.
- One nurse practitioner file did not include the full collaborative agreement between the nurse practitioner and the supervising physician. The file included only a print-out from the Mississippi Board of Nursing Licensee Gateway.
- Regarding verification of member eligibility, the Magnolia website page at https://www.magnoliahealthplan.com/providers/resources/eligibility-verification.html states, "Eligibility can be verified through:" but does not provide any information.
- The Provider Manual does not list restrictions on a PCP's ability to request reassignment of a member to another PCP.
- Magnolia's Provider Manual includes information about preventive health guidelines and directs the reader to the website for a full list of preventive health guidelines. However, the link in the Provider Manual (www.magnoliahealthplan.com/providers/quality-improvement/practice-guidelines) is incorrect and takes the user to a page that only says "Error."
- The total sample size for the Provider Satisfaction Survey was 2000, and 183 providers responded for a 9.2% response rate. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings.

Corrective Actions

- Ensure credentialing files contain the complete collaborative agreement for nurse practitioners.

Recommendations

- Reinforce Credentialing Committee attendance expectations with committee members and take necessary steps to replace or remove members who do not meet the attendance expectations.
- Revise the Magnolia website to include the methods available for verifying member eligibility.
- Include all pertinent information about PCP requests to reassign members to another PCP, including circumstances for when this is inappropriate, in the Provider Manual.
- Revise the Provider Manual to include the correct URL for the preventive health guidelines on Magnolia's website.

- Analysis of barriers to gathering Provider Satisfaction Survey responses should be considered and any methods to address those barriers implemented. This will ensure a greater representation of the PCP, specialist, and behavioral health provider population on the satisfaction surveys.

III. Member Services

42 CFR § 438.56, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F

The previous EQR noted deficiencies related to member rights and responsibilities referenced in various documents and on the plan website. Findings of the current EQR confirmed Magnolia corrected the previously identified issues. See *Table 14: Previous Member Rights and Responsibilities CAP Items*.

Table 14: Previous Member Rights and Responsibilities CAP Items

Standard	EQR Comments
III A. Member Rights and Responsibilities	
2. Member rights include, but are not limited to, the right: 2.2 To privacy and confidentiality, both in their person and in their medical information;	Policy MS.MBRS.25, Member Rights and Responsibilities, does not include the member's right, "To privacy and confidentiality, both in their person and in their medical information." During the onsite teleconference, Magnolia explained the policy was updated and that they would submit it. Upon review, CCME still could not identify that the requirement was included. *Corrective Action: Edit Policy MS.MBRS.25, Member Rights and Responsibilities, to include all member rights as required in CAN Contract, Section 6 (J).*
Magnolia's response: Policy updated to include: To privacy and confidentiality, both in their person and in their medical information	
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.	Policy MS.MBRS.25, Member Rights and Responsibilities does not include the requirement that members have the responsibility to notify the Plan for changes in family size, address changes, or other health care coverage. During the onsite teleconference Magnolia explained the policy was updated and stated they would submit it. Upon review, CCME still could not identify that this requirement was included. *Corrective Action: Edit Policy MS.MBRS.25, Member Rights and Responsibilities, to include all member responsibilities as required in the CAN Contract, Section 6 (J).*
Magnolia's response: Policy updated	

New member packets are described in Policy MS.MBRS.01, New Member Packet/Member ID card, Policy MS.MBRS.02, Member Handbook. Members are provided a New Member Packet within 14 days after Magnolia receives the member's enrollment data from DOM. The Provider Directory is made available electronically on the Magnolia website and the

printed version is available upon request. Limits of coverage, maximum allowable benefits, and no cost services for routine, urgent, or emergent healthcare needs are outlined in the Member Handbook. Policies and procedures are in place outlining steps to be taken for member enrollment and disenrollment.

Members are provided with a toll-free access number, an automated voice system, or a live person to address questions or concerns. Policy MS.MBRS.10, Member Service Calls/Hotline, and Policy MS.PRVR.03, Toll-free Provider Telephone Hotline, state Magnolia maintains a toll-free Member Services and Provider Services call center as required. The 24-Hour Nurse Advice Line is available 24 hours a day, seven days a week, including holidays. Call Center hours of operation are consistently identified on the Magnolia website, in the Member Handbook, and in the Provider Manual. Call Center agents have appropriate call scripts and work processes to assist members and providers, such as scripts for Member Returning Calls, Handling Behavioral Health Crisis Calls, Provider Services Escalation, and Pharmacy Calls. Training is mandated upon hire and at least quarterly with trainings logged. Recorded calls are used as training tools for quality improvement efforts. Member and provider incoming and outgoing call activity is audited and monitored for quality improvement purposes.

During the previous EQR, an issue was identified with documentation in the Provider Manual related to the call center hours of operation. As confirmed during the current EQR, Magnolia corrected the documentation in the Provider Manual. See *Table 15: Previous Call Center CAP Items*.

Table 15: Previous Call Center CAP Items

Standard	EQR Comments
III C. Call Center	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	Policies MS.MBRS.10, Member Service Calls/Hotline and MS.PRVR.03, Toll-free Provider Telephone Hotline state Magnolia maintains a toll-free Member Services and Provider Services call center as required. The 24-Hour Nurse Advice Line has nurses available 24 hours a day, 7 days a week, including holidays. Magnolia ensures members have access to a toll-free number, an automated voice system, or a live person to address questions or concerns. CCME discussed the Provider Manual incorrectly lists hours of operation from 8:00 am – 5:00 pm; the correct hours are from 7:30 am to 5:30 pm. This was a Recommendation during the 2019 EQR. *Corrective Action: Correct the Provider Manual to reflect the Provider Services operating hours are 7:30 am to 5:30 pm CST, as required by the CAN Contract, Section 7 (H) (I).*

Standard	EQR Comments
Magnolia's response: Updated Draft Provider Manual submitted. Page 9 - Provider Services Call Center Hours of Operation - updated to 7:30 – 5:30 CST.	

Magnolia ensures the provision of screening, preventive, and medically necessary diagnostic and treatment services for members through the month of their 21st birthday, as stated in Policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Service, and Policy MS.QI.20.01, EPSDT Notification System. Policies describe processes and methods for notification, tracking, and follow-up of the EPSDT services and address barriers for low utilization by creating interventions to encourage members to use the services.

CCME discussed the efforts planned by the Community Relations team. Opportunities for in-person events are in place to provide education "where members live, work, play, and worship." Books, booklets, school and parent collaboration, and provider groups, are offered as resources.

Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F

Definitions of grievance terminology and information about grievance filing and handling processes and requirements are outlined in Policy MS.MBRS.07, Member Grievance and Complaints Process, the Member Handbook, the Provider Manual, and on Magnolia's website. Information for filing by an Authorized Representative was referenced in policy and on the Magnolia website.

Per Policy MS.MBRS.07, Member Grievance and Complaints Process, the investigation and resolution process for grievances shall be completed within 30 calendar days of the date the grievance is received by Magnolia, or expeditiously as the members health condition requires, and shall include a resolution letter to the grievant.

Of the randomly selected grievance files submitted during the 2021 EQR, there were no identified patterns of noncompliance with the receipt, acknowledgement, investigation, and resolution notifications.

During the previous EQR, Magnolia's Member Grievance and Complaints Process Policy (MS.MBRS.07) was found to include incomplete information about grievance record retention requirements. The current EQR confirmed the issue was corrected. See *Table 16: Previous Grievances CAP Items*.

Table 16: Previous Grievances CAP Items

Standard	EQR Comments
III G. Grievances	
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: 1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	Policy MS.MBRS.07, Member Grievance and Complaints Process, indicates grievance records are retained for a minimum of 10 years; however, it does not specify that grievance records will be retained "during the entire term of the Contract and for a period of 10 years thereafter," as noted in the *CAN Contract, Section 11 (A)*. *Corrective Action: Edit Policy MS.MBRS.07, Member Grievance and Complaints Process, to include the complete grievance requirement from the CAN Contract, Section 11(A).*
Magnolia's response: Policy updated	

Member Satisfaction Survey

Member Satisfaction Survey validation was conducted by CCME based on the CMS Survey Validation Protocol. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. Magnolia contracts with SPH Analytics Research, a certified CAHPS survey vendor, to conduct the Adult and Child Surveys.

The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS. The generalizability of the survey results is difficult to discern due to low response rates (15.9%) with 214 completed surveys out of a sample of 1,342. For the Child survey, generalizability of the survey results is also difficult to discern due to low response rates (9.4%) with 216 completed surveys out of 2,310 sampled. For the Child CCC survey, generalizability of the survey results is also difficult to discern due to low response rates. The general population surveys were 355 for a 10.2% response rate. The sample size was 1,650 for the general population. The total population completed surveys were 161 for a 9.8% response rate.

As noted in *Figure 4: Member Services Findings*, Magnolia achieved "Met" scores for 100% of the Member Services Standards.

Figure 4: Member Services Findings

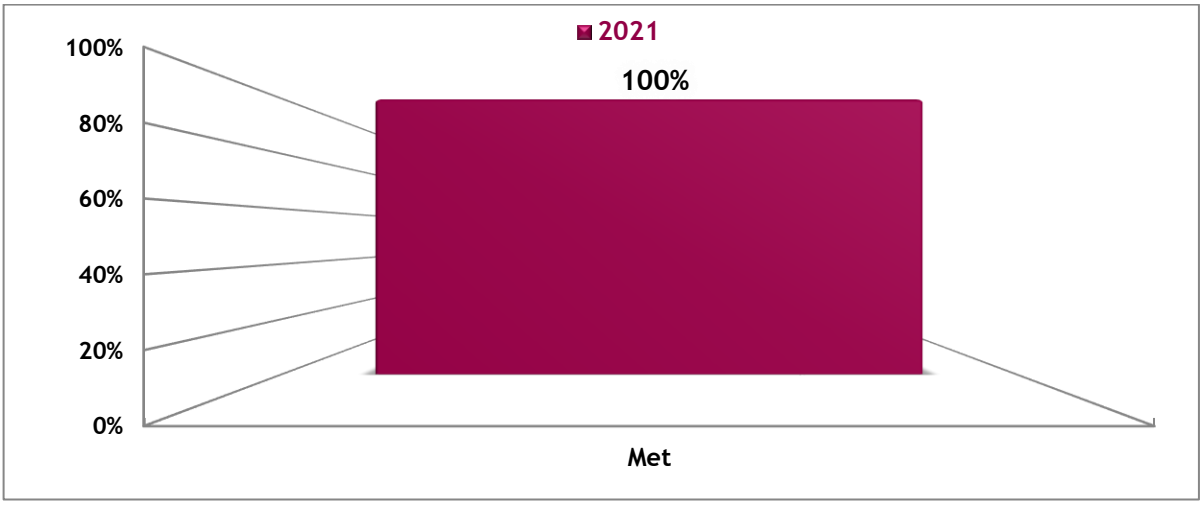


Table 17: Member Services

Section	Standard	CAN 2020 Review	CAN 2021 Review
Member Rights and Responsibilities	Member rights include, but are not limited to, the right: To privacy and confidentiality, both in their person and in their medical information	Partially Met	Met
Call Center	The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals	Partially Met	Met
Grievances	Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021

Strengths

- The Provider Manual was revised to reflect the Provider Services hours of operation are 7:30 am to 5:30 pm CST.
- Magnolia's Policy MS.MBRS.25, Member Rights and Responsibilities, the Member Handbook, the Provider Manual, and on the plan website. Policy edits were made to reflect all contract specific rights and responsibilities.

IV. Quality Improvement

42 CFR §438.330 and 42 CFR Part 441, Subpart B

Magnolia provided the 2021 MississippiCAN Quality Management Program Description, which included the program objectives or priorities and goals and the program's structure and scope. The QI Program Description describes Magnolia's efforts to reduce health disparities through their cultural competency program. Magnolia also assesses and identifies interventions to address health disparities at a statewide and regional level. Magnolia monitors utilization patterns by performing assessments of utilization data to identify potential over- and under-utilization issues or practices. It uses various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services.

Magnolia's Board of Directors has authority, responsibility, and oversight of the development, implementation, and evaluation of the Quality Program. The Board is responsible for evaluating the QI Program Description and the Quality Work Plan to assess whether program objectives were met and recommends adjustments when necessary. At least annually, Magnolia provides information to members and providers regarding the QI Program. On the Magnolia website, a copy of the 2021 QI Program Description and information regarding how to obtain information on the program evaluation was included.

Magnolia develops a QI Work Plan annually after completing the Quality Program Evaluation for the previous year. The 2020 and 2021 QI Work Plans were provided for review. Both work plans included all ongoing QI activities, the responsible party, and target or completion dates. The work plan is presented to the Quality Improvement Committee (QIC) at least annually for review and approval.

The Board delegates the operating authority of the QI program to the QIC. Magnolia's senior management staff, clinical staff, and network practitioners serve on the QIC and are involved in the implementation, monitoring, and direction of the relative aspects of the QI program. The QIC is the senior leadership committee accountable to the Board of Directors. The purpose of this committee is to perform oversight of all QI activities. This committee is responsible for the review and monitoring all clinical, physical, and quality activities to assess the appropriateness of care delivered and to continuously enhance and improve the quality of services. The QIC acts as an oversight committee and receives reports from all Magnolia sub-committees. The Performance Improvement Team is an internal cross-functional quality improvement team that is responsible for gathering and analyzing data, identifying barriers, resolving problems, making recommendations, and reporting to the QIC. Magnolia's Quality Task Force committee is responsible for monitoring HEDIS rate trends, identifying data concerns, and directing interventions.

The Chief Medical Director chairs the QIC. Voting members include Magnolia's senior leaders, representing all departments of the organization, and five network providers. Their specialties include Pediatrics, Family Practice, Psychiatry, and a family nurse practitioner. The QIC meets at least quarterly. However, additional meetings may be scheduled as needed. A minimum of five members including three plan staff and two external physicians must be present for a quorum. Minutes for each meeting are drafted and distributed within 30 days of the meeting. The minutes are approved at the next scheduled meeting.

Per policy MS.QI.23, Provider Profiling Program, Magnolia uses the Provider Profiling Program and Provider Analytics to measure provider performance. Measures include per member per month cost, utilization data, peer group comparisons, patient engagement analysis, quality measure trends, and readmissions. Monthly Provider Analytic dashboards are available in the Provider Analytics section of Magnolia's Provider Web Portal. The Medical Director or Quality Improvement Designee will meet with providers to discuss the dashboard results, identify barriers, and determine what interventions are necessary for performance improvement.

Magnolia monitors compliance with preventive health and clinical practice guidelines annually through review of HEDIS measures such as Diabetes Care, Prenatal and Postpartum Care, Childhood Immunizations, and Annual Child Wellness exams. Last year, CCME received policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines. According to Magnolia staff, this policy was retired and replaced with policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines. This new policy addresses the development, adoption, revision, and performance monitoring.

Magnolia provides coverage for a full range of Early and Periodic Screening, Diagnostic & Treatment (EPSDT) services as required by DOM. Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service, describes the process Magnolia uses to monitor compliance with the EPSDT program requirements and initiate interventions to improve compliance for providers and members. Per policy MS.QI.20, Magnolia's EPSDT Coordinator will monitor claims to identify members with any abnormal finding on an EPSDT screening. If there is no evidence that treatment was sought, the EPSDT Coordinator will contact the provider and member to assist in arranging an appointment for follow-up.

During the previous EQR, CCME recommended Magnolia update the EPSDT tracking report to identify members needing follow-up care after an EPSDT screening and include the CPT codes and dates or notes regarding the contact made. The sample EPSDT tracking report provided for this EQR showed evidence this Recommendation was implemented.

Magnolia's QI Program Evaluation 2020 summarizes the competed and going QI activities and evaluates the overall effectiveness of the program. The 2020 QI Program Evaluation covers activities completed between January 1, 2020, and December 31, 2020. The QI Program Evaluation received for this EQR seemed to be a "draft." There were tracked changes or notes on page 90. According to Magnolia, this copy was a final and had been approved by the QIC. Overall, the QI Program Evaluation was well done and there were no issues.

Performance Measure Validation

42 CFR §438.330 (c)

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the Performance Measures (PMs) identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population. DOM has selected a set of PMs to evaluate the quality of care and services delivered by Magnolia to its members. PM validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS® measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the PM rates following the CMS-developed protocol for validating PMs. The final PM validation results reflected the measurement period of January 1, 2020, through December 31, 2020.

Per the contract between the CCOs and DOM, the CCOs are required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, DOM required each CCO to undergo an NCQA HEDIS Compliance Audit. Magnolia contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Aqurate reviewed the CCOs' final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Magnolia. Aqurate found that Magnolia's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2020. During the audit process, it was noted by Magnolia's HEDIS auditor that Magnolia needed to improve its processes for providing data for various audit steps in a timely manner to avoid the risk of missing critical NCQA deadlines.

All relevant CAN HEDIS PMs were compared for the current review year (MY 2020) to the previous year (MY 2019) and the changes from 2019 to 2020 are reported in *Table 18: CAN HEDIS Performance Measure Results*. Changes in rates shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 18: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	78.59%	40.58%	-38.01%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	54.74%	53.53%	-1.21%
Counseling for Nutrition	53.53%	46.96%	-6.57%
Counseling for Physical Activity	43.55%	40.63%	-2.92%
Childhood Immunization Status (cis)			
DTaP	78.35%	71.53%	-6.82%
IPV	91.97%	90.02%	-1.95%
MMR	89.05%	89.29%	0.24%
HiB	87.59%	85.89%	-1.70%
Hepatitis B	91.97%	86.62%	-5.35%
VZV	88.81%	88.81%	0.00%
Pneumococcal Conjugate	79.32%	73.97%	-5.35%
Hepatitis A	79.56%	81.02%	1.46%
Rotavirus	79.81%	75.91%	-3.90%
Influenza	34.55%	31.14%	-3.41%
Combination #2	77.13%	67.88%	-9.25%
Combination #3	75.18%	65.21%	-9.97%
Combination #4	66.91%	61.31%	-5.60%
Combination #5	68.13%	58.88%	-9.25%
Combination #6	31.63%	26.52%	-5.11%
Combination #7	61.56%	55.47%	-6.09%
Combination #8	29.68%	26.03%	-3.65%
Combination #9	28.47%	24.57%	-3.90%
Combination #10	26.76%	24.09%	-2.67%
Immunizations for Adolescents (ima)			
Meningococcal	59.12%	59.37%	0.25%
Tdap/Td	75.18%	79.32%	4.14%
HPV	16.79%	25.79%	9.00%
Combination #1	58.15%	58.88%	0.73%
Combination #2	15.82%	24.82%	9.0%
Lead Screening in Children (lsc)	72.82%	72.71%	-0.11%
Breast Cancer Screening (bcs)	56.74%	53.86%	-2.88%
Cervical Cancer Screening (ccs)	61.56%	57.18%	-4.38%
Chlamydia Screening in Women (chl)			
16-20 Years	50.29%	47.2%	-3.09%
21-24 Years	62.01%	60.75%	-1.26%
Total	52.02%	49.23%	-2.79%

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Appropriate Testing for Pharyngitis (3-17)	72.37%	75.36%	2.99%
Appropriate Testing for Pharyngitis (18-64)	57.08%	61.36%	4.28%
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	70.56%	73.64%	3.08%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	28.38%	26.49%	-1.89%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	45.77%	45.04%	-0.73%
Bronchodilator	76.02%	77.56%	1.54%
Asthma Medication Ratio (amr)			
5-11 Years	79.47%	81.52%	2.05%
12-18 Years	71.15%	70.24%	-0.91%
19-50 Years	51.37%	55.41%	4.04%
51-64 Years	43.62%	45.9%	2.28%
Total	69.99%	71.09%	1.10%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	41.85%	45.74%	3.89%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	67.24%	60%	-7.24%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	73.48%	72.68%	-0.80%
Statin Adherence 80% - 21-75 years (Male)	52.12%	57.18%	5.06%
Received Statin Therapy - 40-75 years (Female)	73.36%	71.52%	-1.84%
Statin Adherence 80% - 40-75 years (Female)	48.05%	49.32%	1.27%
Received Statin Therapy - Total	73.42%	72.05%	-1.37%
Statin Adherence 80% - Total	50.06%	52.97%	2.91%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	87.83%	87.59%	-0.24%
HbA1c Poor Control (>9.0%)	55.23%	55.96%	0.73%
HbA1c Control (<8.0%)	35.28%	38.2%	2.92%
Eye Exam (Retinal) Performed	70.32%	65.94%	-4.38%
Blood Pressure Control (<140/90 mm Hg)	47.45%	53.28%	5.83%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	58.41%	59.43%	1.02%
Statin Adherence 80%	44.61%	50.65%	6.04%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Effective Acute Phase Treatment	40.34%	46.04%	5.70%
Effective Continuation Phase Treatment	24.98%	28.51%	3.53%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	60.67%	59.25%	-1.42%
Continuation and Maintenance (C&M) Phase	72.36%	72.68%	0.32%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	67.52%	64.72%	-2.80%
6-17 years - 7-Day Follow-Up	39.85%	41.2%	1.35%
18-64 years - 30-Day Follow-Up	56.33%	59.05%	2.72%
18-64 years - 7-Day Follow-Up	31.41%	34.6%	3.19%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	62.96%	62.24%	-0.72%
7-Day Follow-Up	36.39%	38.33%	1.94%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	56.65%	50%	-6.65%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	36.95%	31.76%	-5.19%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	43.97%	43.99%	0.02%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	25.63%	24.68%	-0.95%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	48.25%	45.91%	-2.34%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	29.45%	26.94%	-2.51%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	NA	3.13%	NA
7-Day Follow-Up: 13-17 Years	NA	3.13%	NA
30-Day Follow-Up: 18+ Years	5.57%	5.67%	0.10%
7-Day Follow-Up: 18+ Years	2.93%	3.55%	0.62%
30-Day Follow-Up: Total	5.41%	5.41%	0.00%
7-Day Follow-Up: Total	2.97%	3.5%	0.53%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	70.74%	66.18%	-4.56%

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	69.13%	69.76%	0.63%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	76.92%	73.17%	-3.75%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	57.60%	57.84%	0.24%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	39.33%	30.14%	-9.19%
Cholesterol Testing (1-11)	28.65%	23.67%	-4.98%
Blood Glucose and Cholesterol Testing (1-11)	25.04%	19.9%	-5.05%
Blood Glucose Testing (12-17)	48.18%	41.84%	-6.34%
Cholesterol Testing (12-17)	32.82%	28.01%	-4.81%
Blood Glucose and Cholesterol Testing (12-17)	28.98%	24.91%	-4.07%
Blood Glucose Testing (Total)	44.30%	36.85%	-7.45%
Cholesterol Testing (Total)	31.00%	26.16%	-4.84%
Blood Glucose and Cholesterol Testing (Total)	27.26%	22.77%	-4.49%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	NR	NR
Appropriate Treatment for Children with URI (uri)			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	69.69%	70.98%	1.29%
Appropriate Treatment for Upper Respiratory Infection (18-64)	66.18%	55.77%	-0.41%
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	68.02%	69%	0.98%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	45.29%	43.65%	-1.64%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	37.16%	35.97%	-1.19%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	43.76%	42.1%	-1.66%
Use of Imaging Studies for Low Back Pain (lbp)	71.96%	72.59%	0.63%
Use of Opioids at High Dosage (hdo)	1.46%	1.18%	-0.28%
Use of Opioids from Multiple Providers (uop)			

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Multiple Prescribers	15.27%	13%	-2.27%
Multiple Pharmacies	4.19%	1.92%	-2.27%
Multiple Prescribers and Multiple Pharmacies	2.31%	0.93%	-1.38%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	7.79%	2.93%	-4.86%
18-64 years - >=31 Days covered	3.49%	1.89%	-1.60%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	7.79%	2.95%	-4.84%
Total - >=31 Days covered	3.48%	1.9%	-1.58%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	88.06%	84.87%	-3.19%
45-64 Years	92.53%	91.1%	-1.43%
65+ Years	80.19%	80.18%	-0.01%
Total	90.02%	87.46%	-2.56%
Annual Dental Visit (adv)			
2-3 Years	56.15%	41.82%	-14.33%
4-6 Years	76.79%	61.08%	-15.71%
7-10 Years	77.86%	62.82%	-15.04%
11-14 Years	73.63%	61.27%	-12.36%
15-18 Years	65.24%	55.3%	-9.94%
19-20 Years	44.15%	36.67%	-7.48%
Total	71.08%	57.72%	-13.36%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	70.00%	67.35%	-2.65%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	3.33%	2.04%	-1.29%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	68.67%	72.06%	3.39%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	3.00%	8.1%	5.10%
Total: Initiation of AOD Treatment: 13-17 Years	66.67%	69.66%	2.99%
Total: Engagement of AOD Treatment: 13-17 Years	3.17%	7.87%	4.70%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	40.77%	42.09%	1.32%

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	4.59%	4.27%	-0.32%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	31.97%	29.25%	-2.72%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	12.12%	10.49%	-1.63%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	39.90%	40.5%	0.60%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.54%	5.25%	0.71%
Total: Initiation of AOD Treatment: 18+ Years	36.73%	37.84%	1.11%
Total: Engagement of AOD Treatment: 18+ Years	6.27%	6.25%	-0.02%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.69%	43.55%	1.86%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.55%	4.14%	-0.41%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	31.98%	29.32%	-2.66%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	12.07%	10.46%	-1.61%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	43.50%	45.27%	1.77%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.35%	5.68%	1.33%
Total: Initiation of AOD Treatment: Total	39.09%	40.93%	1.84%
Total: Engagement of AOD Treatment: Total	6.03%	6.41%	0.38%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	96.35%	92.21%	-4.14%
Postpartum Care	67.15%	74.45%	7.30%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 years	69.31%	64.21%	-5.1%
12-17 years	66.09%	67.4%	1.31%
Total	67.53%	66.02%	-1.51%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	56.57%	51.78%	-4.79%
15 Months-30 Months		66.67%	NA
Child and Adolescent Well-Care Visits (WCV)			
3-11 years		41.16%	NA
12-17 years		35.62%	NA
18-21 years		20.05%	NA
Total		37.65%	NA

NA: Indicates denominator was too small or data were not available; NR: Not reported.

For HEDIS MY 2020, there were no measure rates that had a greater than 10% improvement. However, given the difficulties due to the COVID-19 pandemic, there were very few measures that showed a greater than 10 percentage-point decline. As shown, the following HEDIS MY 2020 CAN measure rates had a substantial decline (greater than 10%) from the previous HEDIS rate (2019):

- The Adult BMI Assessment (aba) measure declined by over 38 percentage points. This can be attributed to the fact that the measure is no longer a HEDIS measure. The HEDIS measure was a hybrid measure, and the data was collected administratively and via medical record abstraction. The state measure specifications require only administrative data. This is a significant difference, and the measure rates should be compared with caution.
- For the Annual Dental Visit, nearly all indicators had a greater than 10 percentage point decline.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. Aqurate conducted additional source code review, medical record review validation, and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Several aspects crucial to the calculation of PM data included: data integration, data control, and documentation of PM calculations. The following are some of the main steps included in Aqurate's validation process:

- **Data Integration**—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by Magnolia, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined that the data integration processes for Magnolia were acceptable.
- **Data Control**—Magnolia's organizational infrastructure must support all necessary information systems; its quality assurance practices, and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated Magnolia's data control processes and determined that the data control processes in place were acceptable.
- **Performance Measure Documentation**—Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by Magnolia. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation by Magnolia was acceptable. Magnolia was unable to provide responses for rate

comparison concerns effectively. It is recommended that Magnolia improve processes around calculation, reporting and verification of the rates reported for DOM-required Adult and Child Core set measures.

The measure rates for the CAN population reported by Magnolia for 2020 are listed in *Table 19*: *CAN Non-HEDIS Performance Measure Rates*.

Table 19: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate
Adult Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)	
Ages 18 - 64	0.57%
Ages 65+	0.00%
Total	0.57%
Maternal and Perinatal Health	
PC-01: ELECTIVE DELIVERY (PC-01)	
Women with elective vaginal deliveries or elective cesarean sections	0.00%
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)	
Most or moderately effective contraception – 3 days	13.75%
Most or moderately effective contraception – 60 days	47.02%
LARC - 3 Days	0.88%
LARC - 60 Days Reported	9.66%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)	
Most or moderately effective contraception rate	25.58%
LARC Rate	3.39%
Care of Acute and Chronic Conditions	
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)	
Ages 18 - 64	29.44
Ages 65+	0.00
Total	29.38
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)	
Ages 40 - 64	87.85
Ages 65+	160.77
Total	88.21
HEART FAILURE ADMISSION RATE (PQI-08)	
Ages 18 - 64	59.86
Ages 65+	160.77

Measure	MY 2020 Rate
Total	60.07
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)	
Ages 18 - 39	3.07
HIV VIRAL LOAD SUPPRESSION (HVL - AD)	
Ages 18 - 64	12.43%
Ages 65+	NA
Total	12.19%
Behavioral Health Care	
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)	
Ages 18 - 64	1.28%
Ages 65+	NA
Total	1.28%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)	
Ages 18 - 64	3.39%
Ages 65+	NA
Total	3.38%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)	
Overall	32.73%
Prescription for Buprenorphine	32.32%
Prescription for Oral Naltrexone	0.74%
Prescription for Long-acting, injectable naltrexone	0.00%
Prescription for Methadone	0.08%
Child Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)	
Ages 12 - 17	0.87%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	3.09%
Age 2 Screening	6.03%
Age 3 Screening	5.56%
Total Screening	4.84%
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NA
Maternal and Perinatal Health	
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	
Most or moderately effective contraception – 3 days	2.11%

Measure	MY 2020 Rate
Most or moderately effective contraception - 60 days	45.25%
LARC - 3 Days	0.79%
LARC - 60 Days Reported	12.14%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception rate	30.66%
LARC Rate	2.65%
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)	
Numerator 1 At Least One Sealant	NR
Numerator 2 All Four Molars Sealed	NR
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	
Ages 1 - 20	46.13%

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate

Magnolia did not report one non-HEDIS measure as required by DOM. The measure was the Sealant Receipt On Permanent First Molars (SFM-CH). It is recommended that Magnolia work proactively with DOM for clarification on measures that are required to be reported.

Performance Improvement Project Validation

42 CFR §438.330 (d)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

DOM requires the CCOs to conduct PIPs that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child - Asthma and Adult - COPD).

For the previous EQR, Magnolia submitted four PIPs for validation that addressed the DOM-required topics. All four PIPS scored in the "High Confidence in Reported Results" range and met the validation requirements. CCME provided Recommendations regarding

the documented, quantitative improvements in processes or outcomes of care presentation in the PIP documents. For the current EQR, Magnolia provided four PIP documents for validation. It was noted that the Improving Pregnancy Outcomes with Makena PIP was retired, and the Reducing Preterm Births PIP was submitted. All the PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions are also included.

The Behavioral Health Readmissions PIP aimed at reducing the 30-day psychiatric readmission rates in Hinds County, Brentwood, and MS State Hospital. For this validation, the PIP showed a substantial increase in the readmission rate (2020 annual rate) to 27.69% from the previous year's rate of 13.05%. Magnolia felt the increase was due to a decrease in the total number of admissions and unable to contact members. Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Behavioral Health Care Management Team to provide education and support services to promote adherence to treatment plans, assist with scheduling appointments, and enrolling the member in the care management program. The Clinical Provider Trainer will continue to conduct both telephonic and face-to-face visits with all Hinds County Behavioral Health facilities to provide education and resources to aide in the discharge planning process, address any barriers identified in the discharge planning process, and assist with resolving any other identified issues.

Table 20: Behavioral Health Readmissions

Behavioral Health Readmissions	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Telephonic outreach by the Clinical Provider Trainer for Behavioral Health to all Hinds County Behavioral Health facilities to provide education, resources, and address any barriers. • Direct outreach to members discharged from Hinds County BH facilities by the Behavioral Health Team to complete the TOC Assessment.	

The Reducing Preterm Births PIP is a newly initiated PIP with baseline data only. The goal for this PIP is to reduce the preterm birth rate by interventions directed at members with hypertension or pre-eclampsia. The baseline rate was 13.4% with a benchmark of 11.4%.

Table 21: Reducing Preterm Births PIP

Reducing Preterm Births	
Previous Validation Score	**Current Validation Score**
N/A	70/70=100% High Confidence in Reported Results
Interventions	
• Completing Notification of Pregnancy (NOP) as applicable • Enrolling member in the Start Smart for Baby program • Refer to Care Management for continuous follow up • Identify various methodologies to enhance patient education and engagement to increase early intervention. Develop materials on controlling hypertension during pregnancy, distribute to members as needed. • Develop a plan and criteria to distribute blood pressure cuffs to member.	

The goal of the Sickle Cell Disease Outcomes PIP is to increase the compliance rate of Hydroxyurea for members who are prescribed to take the medication. Magnolia did not meet the goal that 47% of members with a diagnosis of Sickle Cell Disease who were dispensed a prescription for Hydroxyurea and remained on the medication during the treatment period. Results were recorded at 35.5% in 2019, 34.7% in 2020, and 20.6% in 2021.

Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Pharmacy Team to provide education on the importance of medication adherence, assessing for potential barriers or concerns, providing education on 90-day fills and converting more prescriptions to 90-day fills, assisting with medication refills as needed, and referring to Care Management as needed. The Pharmacy Team will also continue mailing letters to the providers of members identified as having a new diagnosis of Sickle Cell or a new prescription for Hydroxyurea quarterly to promote collaboration and medication adherence.

Table22: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
Previous Validation Score	**Current Validation Score**
73/74= 99% High Confidence in Reported Results	73/74= 99% High Confidence in Reported Results
Interventions	

Sickle Cell Disease Outcomes
• Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and also on the importance of medication adherence. • Pharmacy Team mailed letters to the Providers of those members identified, encouraging the Provider to discuss medication adherence at the member's next scheduled appointment. • Pharmacy Team outreached all members who received letters to provide education and to address any barriers/concerns. • Referrals to Care Management as needed.

The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and who had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year. This indicator uses the HEDIS measure, Asthma Medication Ratio (AMR). A decrease in percentile range was noted from baseline (71.15%) to remeasurement period 1 (70.24%) with a goal of 76.86%.

For the adult population, this PIP measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. This indicator uses the HEDIS measure, Use of Spirometry testing in the Assessment, and Diagnosis of COPD (SPR). A decrease in percentile range was noted from baseline (28.38%) to remeasurement period 1 (26.49%) with a goal of 36.82%.

Magnolia did not achieve the goal for either study indicator.

Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Population Health Management Team to provide education, offer support services and enrollment into the care management program, Provider education via E-blast, and member/Provider outreach by the Pharmacy Team.

Table 23: Asthma/COPD PIP

Asthma/COPD	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	73/74= 99% High Confidence in Reported Results
Interventions	

Asthma/COPD
• Direct outreach by the Population Health Management Team to non-compliant members identified in both the Asthma Medication Ratio (AMR) and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations. • Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population. • Education on the AMR & SPR measures in provider newsletters by the QI Team.

CCME provided recommendations for the Behavioral Health Readmissions, Sickle Cell Disease Outcomes, and Asthma/COPD PIPs. The recommendations are displayed in *Table 24: Performance Improvement Project Recommendations*.

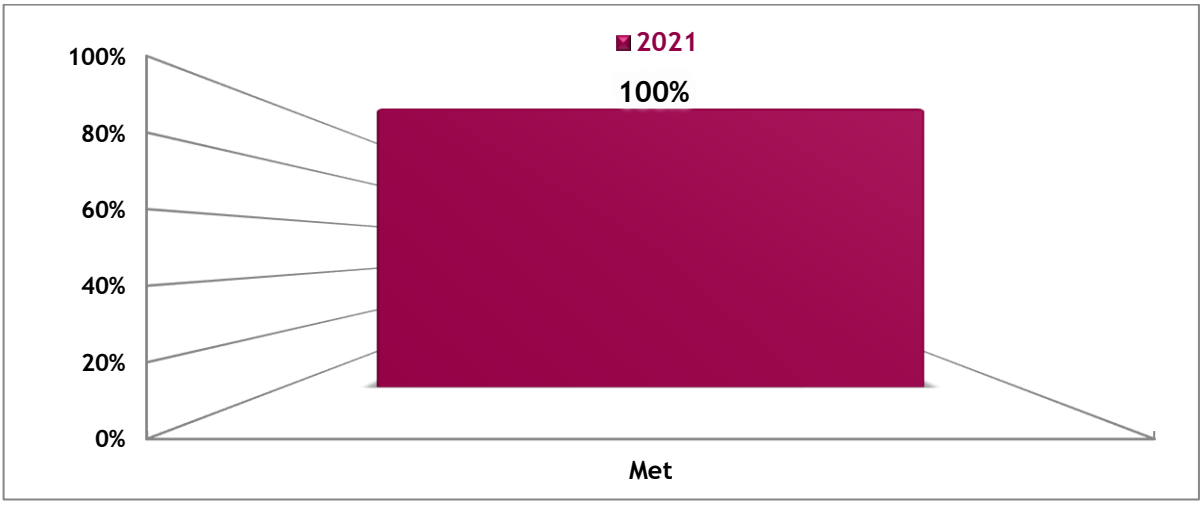
Table 24: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Behavioral Health Readmissions	Was there any documented, quantitative improvement in processes or outcomes of care?	The readmission rate increased for the 2020 annual rate to 27.69% from the previous year's rate of 13.05%. This is a substantial increase in readmissions.	Determine the most effective interventions based on interim analysis and facility-based results. Focus efforts on the primary interventions that seem to be most effective in reducing readmissions.
Sickle Cell Disease Outcomes	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is to increase the rate of members who remain on the medication during the treatment period. The rate decreased from 37.5% in 2019, to 34.7% in 2020, and 20.6% in 2021- the goal is 47%.	Discussion of any potential new interventions should be included in task force and work group meetings regarding PIPs.
Asthma/COPD	Was there any documented, quantitative improvement in processes or outcomes of care?	For the AMR HEDIS rate, 2019 rate is 71.15% and 2020 was 70.24% with a goal of 76.86% (did not improve). COPD SPR HEDIS rate was 28.38% in 2019 and 26.49% in 2020 with a goal of 36.82%.	Continue outreach interventions and determine if methods other than outreach and mailings are available to improve the PIP rates. Determine if other support services may benefit the members.

Details of the validation activities for the PMs and PIPs, and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*.

For this review period, Magnolia met all the requirements in the Quality Improvement section as noted in *Figure 5: Quality Improvement Findings*.

Figure 5: Quality Improvement Findings



Strengths

- Magnolia tracks EPSTD services and monitors claims to identify members with abnormal findings and assists with follow-up as needed.
- Magnolia was fully compliant with all information systems standards and submitted valid and reportable rates for all HEDIS measures in scope of this audit.
- There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures reported. Magnolia followed the measure specifications and produced reportable rates for most measures in the scope of the validation.
- For HEDIS MY 2020, there were no measure rates that had a greater than 10% improvement. However, given the difficulties due to the COVID-19 pandemic, there were very few measures that showed a greater than 10 percentage-point decline.

Weaknesses

- The Behavioral Health Readmissions, Sickle Cell Disease Outcomes, and Asthma COPD PIPs demonstrated no quantitative improvement in process or care.
- The following HEDIS MY 2020 measure rates were determined to be areas of opportunities for Magnolia since their rates had a greater than 10% decline:
    - The Adult BMI Assessment (aba) measure declined by over 38 percentage points. This can be attributed to the fact that the measure is no longer a HEDIS measure. The HEDIS measure was a hybrid measure, and the data was collected administratively and via medical record abstraction. The state measure specifications require only administrative data. This is a significant difference, and the measure rates should be compared with caution.

  - For the Annual Dental Visit, nearly all indicators had a greater than 10 percentage-point decline.

- Magnolia did not report the Sealant Receipt on Permanent First Molars (SFM-CH) non-HEDIS measure as required by DOM.
- During the audit process it was noted by Magnolia's HEDIS auditor that Magnolia needed to improve its processes for providing data for various audit steps in a timely manner to avoid the risk of missing critical NCQA deadlines.
- Magnolia was unable to provide responses for rate comparison concerns effectively.

Recommendations:

- Continue working on provider and member interventions for the PIPs that demonstrated no quantitative improvements in process or care.
- Magnolia should work proactively with DOM for clarification on non-HEDIS measures that are required to be reported.
- Based on Magnolia's HEDIS auditor's findings in the Final Audit report, it is recommended that Magnolia improve the processes for providing data for various audit steps in a timely manner.
- Improve processes around calculation, reporting, and verification of the rates reported for DOM's required Adult and Child Core set measures.

V. Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 208, 42 CFR § 208

Magnolia's Utilization Management (UM) Program is structured within the Population Health Management and Clinical Operations Department. Responsibility of the UM Program is delegated to the Utilization Management Committee (UMC), which reports to the QIC and Magnolia's Board of Directors. The Vice President of Population Health & Clinical Operations is responsible for the daily management of the UM activities.

CCME's UM review included various UM documents, medical necessity determination processes, pharmacy requirements, the Care Management Program, approval, denial, appeal, and care management files, and the Magnolia website. The Utilization Management Program Description 2021 and policies provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services for members in Mississippi. Additionally, Magnolia outlines the program's structure, lines of responsibility, and standards used to make UM decisions. Onsite discussion confirmed Magnolia ensures network practitioners can provide input in UM activities, such as appeals and grievances, and UM guidelines and criteria, during quarterly Clinical Policy Committee (CPC) meetings.

Service authorization requests are reviewed utilizing McKesson's InterQual and internal clinical review criteria such as medical policies or other established criteria. Behavioral health services utilize ASAM criteria in addition to InterQual for behavioral health determinations. Magnolia assesses consistency in criteria application and decision-making through annual inter-rater reliability testing for physician reviewers and clinical reviewers for medical and behavioral health services. All reviewers received passing scores at or above the benchmark of 90%.

Review of approval and denial files reflect consistent decision-making using approved criteria according to an established hierarchy. Physical health, behavioral health, and pharmaceutical utilization decisions are determined by appropriate professionals within required time frames. Approval notices containing all required information were faxed to providers and Adverse Benefit Determination notices were written in clear language for a layperson to understand and included instructions for requesting an appeal. Additional information is requested from providers as needed prior to making an adverse benefit determination.

Envolve Pharmacy Solutions is the pharmacy benefit manager (PBM) and is responsible for implementing pharmaceutical services. Onsite discussion revealed that Magnolia will transition to RxAdvance as the PBM in the near future. Magnolia uses the most current version of the MS Medicaid Program Preferred Drug List (PDL) to fulfill pharmacy requirements. The PDL is accessible on the website.

Magnolia has developed and implemented a Care Management Program and a Population Health Management Program, according to requirements in the *CAN Contract*. The UM Program Description defines and outlines Magnolia's approach to providing medical and behavioral health care management services, and care management policies provide direction and guidance to staff. Additionally, Magnolia ensures Disease Management services and Transitional Care Management activities are provided to identified members.

Care management files reflect staff are providing the appropriate level of case management services according to the member's risk level and needs. Health risk assessments are conducted by qualified licensed health professionals, such as nurses and social workers, who are appropriate for the member's health condition.

Appeals

42 CFR § 438.228,42 CFR § 438, Subpart F

Magnolia has established policies describing processes for handling appeals of adverse benefit determinations that are consistent with requirements in the *CAN Contract* and Federal Regulations. During the onsite, Magnolia confirmed the appeals timeframe begins upon receiving a signed authorization from the member, and the process is documented in Policy MS.UM.08, Appeal of UM Decisions. Definitions of an adverse benefit

determination and an appeal, and who may file an appeal, are correctly documented. Procedures for filling an appeal are clearly provided and consistently documented in policies, the Member Handbook, the Provider Manual, and on the website. Additionally, Magnolia ensures members can contact Member Services to receive appeals information and assistance in languages other than English.

Review of appeal files reflect timely acknowledgement, resolution, and notification of determinations by professionals with appropriate clinical experience. Resolution letters are written clearly and provide instructions for requesting a State Fair Hearing.

As noted in *Table 25*, during the 2020 EQR period, Magnolia had deficiencies in standards related to registering and responding to member appeals. Deficiencies identified included issues with outdated terms for "adverse benefit determination" in the UM Program Description and not clearly describing who can be an authorized representative in the Provider Manual. Magnolia has revised the documents to address these deficiencies.

Table 25: Previous Appeals CAP Items

Standard	EQR Comments
V C. Appeals	
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	The terms "appeal" and "adverse benefit determination," as well as who can file an appeal, are defined in Policy MS.UM.08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, and the Provider Manual. The following documentation issues were identified: •The UM Program Description has outdated terms such as "adverse medical necessity decision" and "adverse determination" instead of the correct term of "adverse benefit determination." •The Member Handbook (page 71) provides examples of people who can file an appeal, but it does not specify these are people who can be the member's authorized representative. •The Provider Manual states that the member's authorized representative can file an appeal, but it does not describe who can be an authorized representative. *Corrective Action: Edit the Utilization Management Program Description to replace outdated terms for "adverse benefit determination." Refer to the CAN Contract, Section 2 (A). Edit the Member Handbook and Provider Manual to clarify and describe who can act as a member's authorized representative.*
Magnolia's response: Updated member handbook on page 73 of the uploaded word document. Also updated the form to read Authorized User Form. Updated UM Program description submitted. Updated Provider Manual submitted Page 58 – Updated grievance section to include the name of the responsible party form (authorized representative form) Page 59 – Added authorized representative description	

As noted in *Figure 6: Utilization Management Findings*, Magnolia received scores of "Met" for 100% of the Utilization Management standards.

Figure 6: Utilization Management Findings

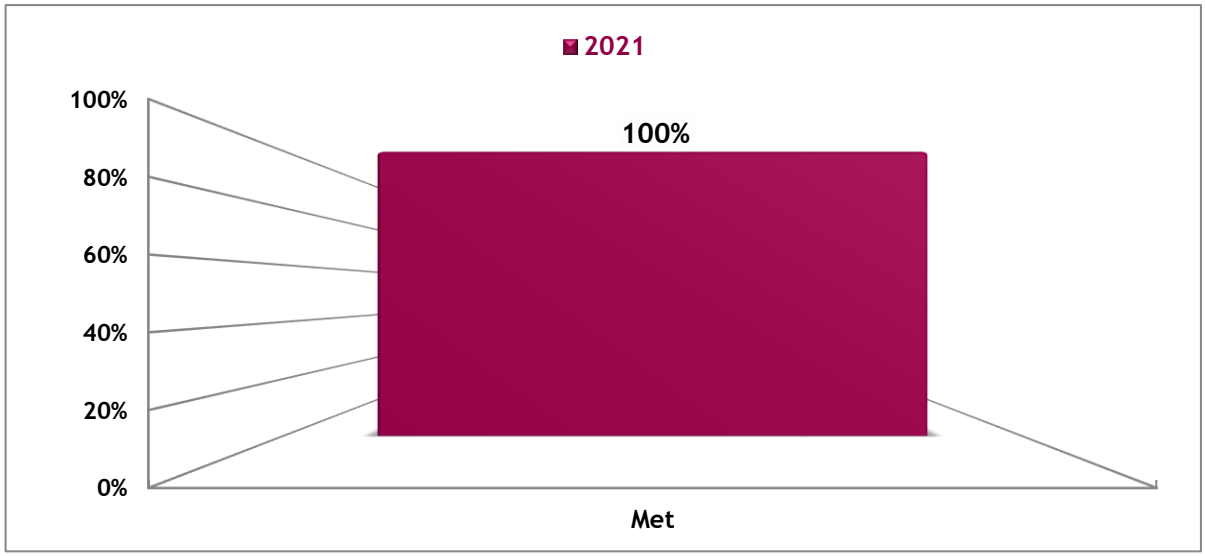


Table 26: Utilization Management

Section	Standard	CAN 2020 Review	CAN 2021 Review
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021

Strengths

- Appeal policies are well-written: the purpose is clearly stated, procedures steps are detailed and divided into appropriate sub-categories, and applicable definitions are included.
- The UM Program Evaluation includes detailed analysis of UM activities and outcomes and provides insight to barriers and interventions to address them.
- The appeal files submitted for review were well organized and included all pertinent information.
- Magnolia is conducting a COVID-19 project that includes outreach and education to all plan members.

VI. Delegation

42 CFR § 438.230

CCME's EQR of Delegation functions examined the submitted delegate list, delegation contracts, and delegation monitoring materials.

Magnolia reported 20 current delegation agreements, as shown in *Table 27: Delegated Entities and Services*.

Table 27: Delegated Entities and Services

Delegated Entities	Delegated Services
Envolve Dental	Dental claims, network, utilization management, credentialing, and quality management
Envolve Vision	Vision services claims, network, utilization management, credentialing, and quality management
Envolve Pharmacy Solutions	Pharmacy claims, network, utilization management, credentialing
Envolve PeopleCare - NurseAdvice Line	24/7 Nurse call center
Medical Transportation Management, Inc. (MTM)	Non-emergency transportation claims, network, utilization management, credentialing, and quality management
National Imaging Associates, Inc. (NIA)	Radiology utilization management
Baptist Memorial Health Care-Baptist Health Services Group Hattiesburg Clinic, PA LSU Healthcare Network (New Orleans) Magnolia Regional Health Center Management and Network Services, LLC Memorial Hospital at Gulfport Mississippi Health Partners Mississippi Physicians Care Network North Mississippi Medical Clinic/North MS Healthlink Ochsner Clinic Foundation Premier Health, Inc. Rush Health Systems St. Jude Children's Research Hospital University of Mississippi Medical Center	Credentialing

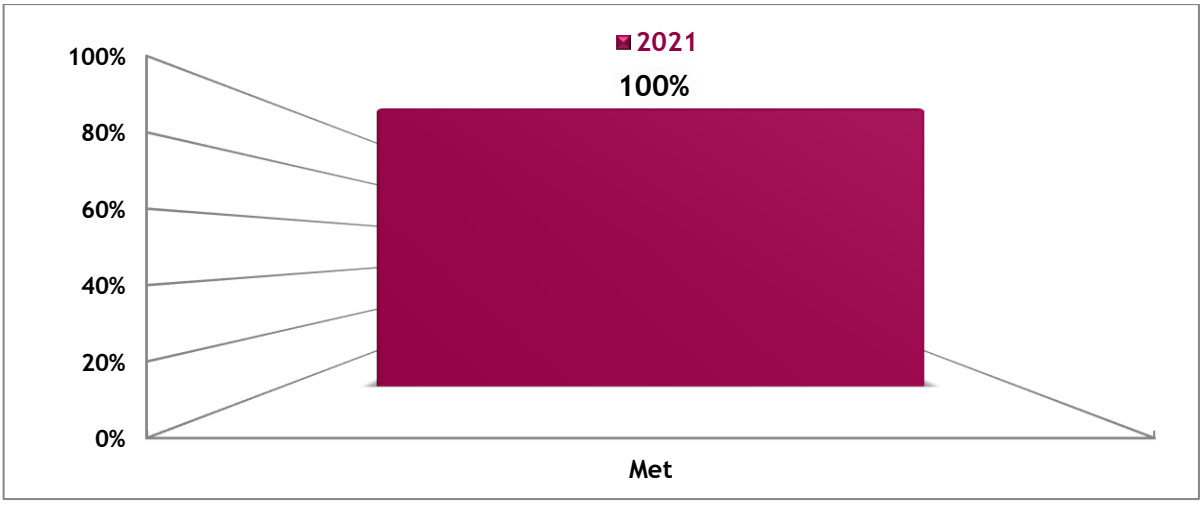
Processes for delegation, annual oversight, and ongoing monitoring are found in Policy MS.QI.14, Oversight of Delegated Vendor Services, and Policy CC.CRED.12, Oversight of Delegated Credentialing.

Prior to implementing a delegation agreement, Magnolia assesses the potential delegate's ability to conduct the delegated activities and services in accordance with State, NCQA, and/or other external requirements. Each new delegation agreement is submitted to DOM for review and approval prior to executing the agreement. Magnolia presented the delegation agreements for each of its delegates. The agreements specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.

Magnolia retains accountability for each delegated service and evaluates the performance of the delegated entities by conducting routine monitoring and a formal, annual assessment to determine whether the delegated activities are being carried out as required. Documentation of preassessment activities, annual oversight, and ongoing monitoring were provided for each of Magnolia's delegated vendors. Tools used in the monitoring and oversight were submitted and include appropriate elements for each of the services delegated. Reports of the monitoring and oversight included documentation of any deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan.

As indicated in *Figure 7: Delegation Findings*, 100% of the standards in the Delegation section were scored as "Met."

Figure 7: Delegation Findings



Strengths

- Delegation agreements are in place with each delegated vendor and specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.
- Monitoring and oversight tools include appropriate elements for each of the services delegated.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

I. Attachment 1: Initial Notice, Materials Requested for Desk Review

July 6, 2021
Mr. Aaron Sisk
Plan President & CEO
Magnolia Health Plan
111 East Capitol Street, Suite 500
Jackson, MS 39201

Dear Mr. Sisk:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2021 External Quality Review (EQR) of Magnolia Health Plan is being initiated. The review will include the MississippiCAN (MSCAN) Program and will be conducted by The Carolinas Center for Medical Excellence (CCME).

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME) and an onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review.

The onsite visit will be conducted on October 18, 2021, through October 19, 2021, for the MississippiCAN Program.

In preparation for the desk review, the items on the enclosed Mississippi CAN Materials Request for Desk Review list should be provided to CCME no later than August 5, 2021.

Please upload all the desk materials electronically to CCME through our secure file transfer website. The file transfer site can be found at: https://eqro.thecarolinascenter.org.

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will simultaneously be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending until CCME grants you the appropriate security clearance.

We would be happy to schedule an education session (via webinar) on how to utilize the file transfer site. We will also send written desk instructions on how to use the file transfer site. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support. Of course, additional information and technical assistance will be provided as needed.

An opportunity for a pre-onsite conference call with your management staff, in conjunction with the DOM, to describe the review process and answer any questions prior to the onsite visit is being offered as well.

Please contact me directly at 803-212-7586 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

External Quality Review 2021 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MississippiCAN (MSCAN) program, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence for the MSCAN program.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base for the MSCAN program. Please include any provider identified limitations on panel size considered in the network assessment.

5. The total number of unique specialty providers for MSCAN as well as the total number of unique primary care providers, broken down by specialty, currently in the network.

6. A current provider list/directory as supplied to MSCAN members.

7. A copy of the current Fraud, Waste & Abuse/Compliance plan for the MSCAN programs and any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

8. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs for MSCAN. Please also submit the Credentialing Program Description and all health plan and corporate credentialing policies and procedures for all provider types.

9. The Quality Improvement work plans for MSCAN for 2020 and 2021.

10. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, Disease/Care Management, and Population Health programs for MSCAN.

11. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN program completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).

    a. For all projects with non-HEDIS measures:

- any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.

b. For projects with measures derived from medical record abstraction:
   - full documentation of the abstraction process and tool used during abstraction, and
   - 15 sample records from those abstracted charts.

c. For projects with measures derived from administrative electronic systems:
   - full source code documentation of how the measure was processed and calculated for the PIP, and
   - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

12. Minutes of all committee meetings in the past year for all committees reviewing or taking action on MSCAN related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.

13. Membership lists and a committee matrix for all MSCAN committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include committee charters if available.

14. Any data for the MSCAN program collected for the purposes of monitoring the utilization (over and under) of health care services.

15. Copies of the most recent physician profiling activities for the MSCAN program conducted to measure contracted provider performance.

16. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews for MSCAN providers.

17. Provide reports for measuring provider adherence to medical record standards for 2020 and 2021.

18. A complete list of all MSCAN members enrolled in the Care Management program from July 2020 through July 2021. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Evidence of any training provided to call center staff on the MSCAN program and changes.

20. A copy of the MSCAN member handbook and any statement of the member bill of rights and responsibilities, if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction surveys for the MSCAN program with a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and any other documentation of the requested scope of work.

22. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on MSCAN program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans, including initial provider orientation, for educating providers on the MSCAN program.

24. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of July 2020 through July 2021.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements for the MSCAN program.

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the MSCAN program. Include copies of the most recent Network Geographic Access Assessment (GeoAccess) reports and provider appointment and after-hours access monitoring.

27. Preventive health practice guidelines recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

28. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

29. For the MSCAN program, a list of physicians currently available for utilization consultation/review and their specialty.

30. A copy of the provider handbook or manual for MSCAN program.

31. A sample provider contract for the MSCAN program.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.

g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of July 2020 through July 2021.

33. For the MSCAN program, a listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

34. Contracts for all delegated entities.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

36. Please provider the following information for Performance Measure validation:

Folder	Requested Document	Description
a.	HEDIS MY 2020 (Measurement Year 2020) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the HUDIS MY 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCAN.
c.	HEDIS MY 2020 Final Audit Report (from Licensed Organization) for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.

Folder	Requested Document	Description
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide the vendor's name and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production.
f.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 f) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite review.*
g.	List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 g) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.*
h.	Rate reporting template populated with data for non-HEDIS measure rates	CCME will provide the rate reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.
1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA. 2. HEDIS Certified Measures SM is a service mark of the NCQA.		

37. Provide a complete list of all services that require prior authorization.

38. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (<u>including provider office site visits as appropriate</u>) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the MSCAN program made in the months of July 2020 through July 2021. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions.

Include any medical information and physician review documentation used in making the denial determination for each file.

d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of July 2020 through July 2021, including any medical information and approval criteria used in the decision.

   Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org**
- **should be submitted in the categories listed.**

II. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2021

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.

2. A policy related to provider orientation and ongoing education. Last year, Policy CC.PRVR.13, Provider Orientations, was submitted but not received this year.

3. A screen shot of the member-level drill-down of quality measures of the Provider Analytic dashboard referenced in policy MS.QI.23, Provider Profiling Program.

Materials should be uploaded to the secure CCME EQR File Transfer site at:
https://egro.thecarolinascenter.org

III. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation CAN
- Member Satisfaction Survey Validation CAN
- HEDIS PM Validation CAN
- PIP Validation CAN

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia CAN**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2020
Review Performed	2021

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

Survey Element		Element Met / Not Met	Comments and Documentation
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The total sample size was 2000 and 183 responded for a 9.2% response rate. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.1% (51 out of 282). *Documentation: 2020 SPH Analytics Provider Satisfaction Report* ***Recommendation**: Analysis of barriers to gathering survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the provider PCP, Specialist, and Behavioral Health population on the satisfaction surveys.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation: 2020 SPH Analytics Provider Satisfaction Report*

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2020
Review Performed	2021

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid.	**MET**	Survey has been tested for validity. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable.	**MET**	Survey has been tested for reliability. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,342, and the total completed surveys was 214 (15.9%). This is a decline from the 2020 rate of 20.3%. This response rate is lower than the NCQA target rate of 40%. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid* ***Recommendation:*** *Continue to work with SPH Analytics to improve response rates. Determine if there are other innovative ways to advertise surveys and increase response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid*

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2020
Review Performed	2021

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid.	**MET**	Survey has been tested for validity. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable.	**MET**	Survey has been tested for reliability. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 3,490 for the total sample. The general population completed surveys were 355 for a 10.2% response rate. The sample size was 1,650 for the general population. The total population completed surveys were 161 for a 9.8% response rate. These response rates are lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid* ***Recommendation:*** *Continue to work with SPH Analytics to improve response rates. Determine if there are other innovative ways to advertise surveys and increase response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child CCC Medicaid*

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2020
Review Performed	2021

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid.	**MET**	Survey has been tested for validity. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable.	**MET**	Survey has been tested for reliability. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 2310, and the total completed surveys was 216 for a 9.4% response rate. This response rate is lower than the NCQA target rate of 40%. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid* ***Recommendation:*** *Continue to work with SPH Analytics to improve response rates. Determine if there are other innovative ways to advertise surveys and increase response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation: MY2020 SPH Analytics Research Final CAHPS 5.1H Report Child Medicaid*

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Met**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**Met**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
NOT APPLICABLE

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measures Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measures Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measures Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	This hybrid measure was reported using only administrative data.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	This hybrid measure was reported using only administrative data.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	This hybrid measure was reported using only administrative data.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	This hybrid measure was reported using only administrative data.
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	This hybrid measure was reported using only administrative data.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**PC-01: ELECTIVE DELIVERY (PC-01)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Met**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**Met**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measures Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI-08)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	10
D1	**10**	**Met**	10
D2	**5**	**Met**	5
N1	**10**	**Met**	10
N2	**5**	**Met**	5
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)**
Reporting Year:	**2021**
Review Performed:	**10/18/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measures Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Not Applicable**	This measure was not reported.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Not Applicable**	This measure was not reported.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Applicable**	This measure was not reported.
Overall assessment			Not Applicable

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Not Applicable	
D1	10	Not Applicable	
D2	5	Not Applicable	
N1	10	Not Applicable	
N2	5	Not Applicable	
N3	5	Not Applicable	
N4	5	Not Applicable	
N5	5	Not Applicable	
S1	5	Not Applicable	
S2	5	Not Applicable	
R1	10	Not Applicable	

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**N/A**
Measure Weight Score	**N/A**
Validation Findings	**N/A**

AUDIT DESIGNATION
NOT REPORTED

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**Magnolia**
Name of PIP:	**ASTHMA/COPD**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	AMR and SPR rates are below the target rates for the health plan.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined. Using HEDIS measures: AMR and SPR
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement rates are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of rate in comparison to benchmarks.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	For the AMR HEDIS rate, 2019 rate is 71.15% and 2020 was 70.24% with a goal of 76.86% (did not improve). COPD SPR HEDIS rate was 28.38% in 2019 and 26.49% in 2020 with a goal of 36.82%. **Recommendation**: Continue outreach interventions and determine if methods other than outreach and mailings are available to improve the PIP rates. Determine if other support services may benefit the members.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	**5**
Step 2		
2.1	10	**10**
Step 3		
3.1	1	**1**
3.2	1	**1**
Step 4		
4.1	NA	**NA**
4.2	NA	**NA**
4.3	NA	**NA**
Step 5		
5.1	10	**10**
5.2	1	**1**
Step 6		
6.1	5	**5**
6.2	1	**1**
6.3	1	**1**
6.4	5	**5**
6.5	1	**1**
6.6	5	**5**
Step 7		
7.1	5	**5**
7.2	10	**10**
7.3	1	**1**
7.4	1	**1**
Step 8		
8.1	10	**10**
Step 9		
9.1	1	**0**
9.2	NA	**NA**
9.3	NA	**NA**
9.4	NA	**NA**

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS (CLINICAL)**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Hinds County has a high rate of readmissions.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement period 1 are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The readmission rate increased for the 2020 annual rate to 27.69% from the previous year's rate of 13.05%. This is a substantial increase in readmissions. **Recommendation:** Determine the most effective interventions based on interim analysis and facility-based results. Focus efforts on the primary interventions that seem to be most effective in reducing readmissions.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	**5**
Step 2		
2.1	10	**10**
Step 3		
3.1	1	**1**
3.2	1	**1**
Step 4		
4.1	NA	**NA**
4.2	NA	**NA**
4.3	NA	**NA**
Step 5		
5.1	10	**10**
5.2	1	**1**
Step 6		
6.1	5	**5**
6.2	1	**1**
6.3	1	**1**
6.4	5	**5**
6.5	1	**1**
6.6	5	**5**
Step 7		
7.1	5	**5**
7.2	10	**10**
7.3	1	**1**
7.4	1	**1**
Step 8		
8.1	10	**10**
Step 9		
9.1	1	**0**
9.2	NA	**NA**
9.3	NA	**NA**
9.4	NA	**NA**

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**Magnolia**
Name of PIP:	**REDUCING PRETERM BIRTHS**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Preterm births have risen 1.6% in last 5 years in MS.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline measure only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of rate in comparison to benchmarks.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline preterm birth rate is 13.4% which is above the benchmark of 11.4%. Only baseline rate is available. Improvement unable to be examined until a remeasurement is conducted.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	**5**
Step 2		
2.1	10	**10**
Step 3		
3.1	1	**1**
3.2	1	**1**
Step 4		
4.1	NA	**NA**
4.2	NA	**NA**
4.3	NA	**NA**
Step 5		
5.1	10	**10**
5.2	1	**1**
Step 6		
6.1	5	**5**
6.2	1	**1**
6.3	1	**1**
6.4	5	**5**
6.5	1	**1**
6.6	5	**5**
Step 7		
7.1	5	**5**
7.2	10	**10**
7.3	NA	**NA**
7.4	1	**1**
Step 8		
8.1	10	**10**
Step 9		
9.1	NA	**NA**
9.2	NA	**NA**
9.3	NA	**NA**
9.4	NA	**NA**

Project Score	**72**
Project Possible Score	**72**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA**
Name of PIP:	**SICKLE CELL DISEASE (CLINICAL)**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	**In 2018, a low percentage of members were compliant with taking their Hydroxyurea.**
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care and health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using a rate with numerator and denominator.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement 1 are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of results are presented in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is to increase the rate of members who remain on the medication during the treatment period. The rate decreased from 37.5% in 2019, to 34.7% in 2020, and 20.6% in 2021- the goal is 47%. **Recommendation**: Discussion of any potential new interventions should be included in task force and work group meetings regarding PIPs
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	**5**
Step 2		
2.1	10	**10**
Step 3		
3.1	1	**1**
3.2	1	**1**
Step 4		
4.1	NA	**NA**
4.2	NA	**NA**
4.3	NA	**NA**
Step 5		
5.1	10	**10**
5.2	1	**1**
Step 6		
6.1	5	**5**
6.2	1	**1**
6.3	1	**1**
6.4	5	**5**
6.5	1	**1**
6.6	5	**5**
Step 7		
7.1	5	**5**
7.2	10	**10**
7.3	1	**1**
7.4	1	**1**
Step 8		
8.1	10	**10**
Step 9		
9.1	1	**0**
9.2	NA	**NA**
9.3	NA	**NA**
9.4	NA	**NA**

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**Magnolia Health Plan MSCAN**
Review Performed:	2021

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy CC.COMP.22, Policy Management, provides guidance for the development, review, approval, and maintenance of policies. The Archer system is used to house policies with email notifications sent internally prior to review due dates.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Aaron Sisk is Magnolia's Plan President and Chief Executive Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 *Chief Operating Officer;	X					The Chief Operating Officer is Sesha Mudunuri.
1.3 Chief Financial Officer;	X					Lewis Peeples Is the Chief Financial Officer.
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Cynthia Bruemleve is the Claims Configuration Manager.
1.6 *Provider Services Manager;	X					Cynthia Douglas is Vice President of Network Development.
1.6.1 *Provider credentialing and education;	X					Kennesha Higgins is Senior Manager for Customer Service.
1.7 *Member Services Manager;	X					
1.7.1 Member services and education;	X					Thirty-two staff support Member Services in the Call Center and locally to provide training and education about new products, services, and resources.
1.8 Complaint/Grievance Coordinator;	X					Tinisha Woodberry is the Clinical Grievance and Appeals Supervisor.
1.9 Utilization Management Coordinator;	X					
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Carrie Mitchell is the Senior Quality Improvement Manager.
1.11 *Marketing, member communication, and/or public relations staff;	X					Mary McDonnieal is the Marketing, Member Communications Manager.
1.12 *Medical Director;	X					The Chief Medical Director is Jeremy Erwin.
1.13 *Compliance Officer.	X					The Compliance Director is Nicole Litton.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 438.224*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia has set an internal benchmark that 99% of clean claims are paid within 30 days and 100% are paid within 90 days. Magnolia provided 12 months of claims processing data for the Information Systems Capabilities Assessment (ISCA) review. The claims data demonstrates that Magnolia regularly exceeds the State's requirements for timeliness.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia relies on the State's 834 files and industry standard claims and encounter forms to collect member data. Additionally, to ensure accuracy and completeness, Magnolia states that submissions with incomplete or missing data elements will result in the claim being rejected or denied.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					HEDIS and HEDIS-like reports are stored and processed with National Committee for Quality Assurance (NCQA) certified HEDIS software. Additionally, Magnolia states that all reports are reviewed both by IT and business owners to ensure data accuracy, validate Performance Measures, and to compare historical performance statistics.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Magnolia has a multifaceted disaster recovery and business continuity plan for its IT resources. The organization has implemented varying strategies to address the differences in its infrastructure which includes both data centers and cloud environments. The recovery and business continuity plans are tested, reviewed, and updated annually. Lastly, it is commendable that the organization's recovery plan

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						includes the ability to failover to an alternate data center.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Centene Business Ethics and Code of Conduct indicates that all employees and Board members are required to read the Business Ethics and Code of Conduct on an annual basis and report to compliance that they have read the Code and whether they have witnessed fraud, waste, abuse, or other misconduct or compliance violations. This training is distributed to all employees through Centene's Learning Management Solution, which houses all responses and is reviewed by Centene's corporate compliance department.
2.2 Identification of the Compliance Officer;						The Compliance Committee Charter outlines the responsibilities of the Compliance Officer.
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						Policy CC.COMP.16, Fraud, Waste, and Abuse Plan, outlines that a fraud, waste, and abuse (FWA) training program is administered in conjunction with Centene's Ethics and Compliance training annually and at new hire orientation. The training is mandatory for all employees, including officers, directors, and managers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Lines of communication;						A toll-free hotline number has been established to report potential FWA activities. The hotline is operated by an independent third party and all referrals are sent directly to a member of the Special Investigative Unit management and analyst team. A FWA email inbox is available for the reporting of suspected fraud.
2.6 Enforcement and accessibility;						
2.7 Internal monitoring and auditing;						Addendum M of the FWA Plan details the processes for receiving and reviewing reports referred for investigation, including what comprises an investigation and the responses to offenses that range from internal action to legal consequences.
2.8 Response to offenses and corrective action;						
2.9 Exclusion status monitoring.						
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Committee Charter as well as the quarterly meeting minutes clearly define the functions of the committee. Voting members and non-voting members are identified to establish a quorum for each meeting.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Policy CC.COMP.16, Addendum M, Fraud, Waste, and Abuse describes the process for initiating an investigation and details the types of investigative reports reviewed internally.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Policy MS.PHAR.15, Pharmacy Lock-In Program, defines processes and requirements for the pharmacy lock-in program.
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy MS.COMP.PRVC.52, Workplace Protection of PHI and Confidentiality Data, outlines guidelines to ensure member and provider Protected Health Information is secure and confidential according to the Health Information Portability and Accountability Act of 1996 (HIPAA) Privacy, HIPAA Security, and Centene confidentiality policies and procedures. The Centene Business Ethics and Code of Conduct indicates that privacy and confidentiality of personal data must be protected in accordance with Company policies and procedures. The Magnolia Health HIPAA Training: Operations Department Training provides information about training points for employees upon hire and the annual renewal periods.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Processes and requirements for credentialing and recredentialing activities are found in: •The Credentialing Program Description •Policy CC.CRED.01, Practitioner Credentialing & Recredentialing •Policy CC.CRED.02, Maintaining Confidentiality of Credentialing Information •Policy MS.CONT.03, Site Assessments for New Provider Contracts •Policy CC.CRED.04, Nondiscriminatory Credentialing and Recredentialing •Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints •Policy CC.CRED.09, Organizational Assessment and Reassessment
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.	X					Magnolia's Credentialing Committee is comprised of network practitioners and health plan staff and is chaired by the Medical Director. The quorum is established as the presence of 50% of the voting members, and the Medical Director and network physician attendees are considered voting members. Providers who meet established criteria are reviewed and approved by a medical director or designated physician. The Credentialing Committee provides advice and expertise for credentialing decisions and reviews credentials for providers who do not meet established thresholds. The Credentialing Committee charter indicates the attendance expectation is 75% of scheduled meetings.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Onsite discussion confirmed that if a committee member does not meet the attendance requirement, the health plan engages with the committee member to discuss the attendance expectations and will take action to replace or remove the member if necessary. Review of the submitted Credentialing Committee minutes revealed that of the 11 meetings reviewed, 1 provider attended only 45% of the meetings, and 2 additional providers attended only 64% of the meetings. The provider who attended only 45% of the meetings was also noted to have poor attendance during the previous EQR. *Recommendation: Reinforce Credentialing Committee attendance expectations with committee members and take necessary steps to replace or remove members who do not meet the attendance expectations.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.		X				The Division of Medicaid requires CCO's contracting with nurse practitioners to collect the complete collaborative agreement between nurse practitioners and collaborating physicians. Onsite discussion confirmed the complete collaborative agreement is collected at initial credentialing for nurse practitioners. However, one nurse practitioner file included only a print-out from the Mississippi Board of Nursing Licensee Gateway. *Corrective Action: Ensure credentialing files contain the complete collaborative agreement for nurse practitioners.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice insurance coverage / claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
3.2 Site assessment.	X					Currently, site visits are not conducted due to restrictions from the COVID-19 pandemic. However, Magnolia reported that a list of providers is being maintained and site visits will be completed when restrictions are lifted.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS Certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.3 Provider office site reassessment, when applicable.	X					
4.4 Review of practitioner profiling activities.	X					
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Procedures for identifying, monitoring, investigating, and analyzing potential or suspected quality of care incidents are addressed in Policy CC.QI.17, Potential Quality of Care Incidents. Magnolia's processes and mechanisms for ongoing monitoring of quality and safety of practitioner services are described in Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting. After an investigation is conducted by the Medical Director, a peer review committee, or by the Credentialing Committee itself, the Credentialing Committee is responsible for deciding if a provider's participation of any practitioner should be suspended, restricted, or terminated.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						MS.PRVR.23, Provider Termination, addresses requirements and processes for termination of providers from the network.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					Policy CC.CRED.09, Organizational Assessment and Reassessment, addresses processes for credentialing and recredentialing of organizational or institutional providers. No issues were identified in the initial credentialing and recredentialing files for organizational providers.
II B. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1) 42 CFR § 438.207*						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.01, PCP Member Panel Reports, and Policy MS.ELIG.08, PCP Notification, describe Magnolia's processes for informing PCPs of their member panel information. Magnolia provides a current PCP Panel/Patient List to all participating PCPs via the secure provider web portal, which is updated within 5 business days of receiving the monthly enrollment file from DOM. Providers may also calling the Provider Services Call Center to verify their member panel and member eligibility.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Within 5 business days of receiving the Member Listing Report from DOM, Magnolia ensures that both participating and non-participating providers can verify enrollment by telephone or by another timely mechanism. Any provider can use the toll-free number on the member's ID card to verify enrollment using the interactive voice response system, 24 hours

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						a day, 7 days a week. All providers may contact a Provider Services Representative during normal business hours to verify member eligibility. Providers may also verify member eligibility via the Mississippi Envision Web Portal. All these methods of verifying eligibility are documented in the Provider Manual. However, the Magnolia website page at https://www.magnoliahealthplan.com/providers/resources/eligibility-verification.html states, "Eligibility can be verified through:" but does not list any information. *Recommendation: Revise the Magnolia website to include the methods available for verifying member eligibility.*
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Policy CC.PRVR.47, Evaluation of Practitioner Availability, describes mechanisms Magnolia's Provider Relations Department uses for monitoring the type, number, and geographic distribution of PCPs and other provider types annually. Standards for geographic access to PCPs are listed in a table within the policy and are compliant with contractual requirements. Magnolia's goal for the percentage of members with the required access to PCPs is 90%. The Geo Access report dated July 19, 2021, confirms correct parameters were used for measuring access to PCPs. Based on the findings of this report, 100% of members have the required access to PCPs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					Policy CC.PRVR.47, Evaluation of Practitioner Availability, describes mechanisms used for monitoring the type, number, and geographic distribution of high-volume (OBGYN) and high-impact (Oncology) specialty care practitioners, and behavioral health practitioners annually. Standards for geographic access to high-volume specialists and prescribing and non-prescribing behavioral health practitioners are listed in a table within the policy and are compliant with contractual requirements. Magnolia's goal for the percentage of members with the required access to non-PCP providers is 90%. The Geo Access reports dated July 19, 2021, confirm correct parameters were used for measuring access to specialists and other providers.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Annual measurements of practitioner types and availability are conducted. Other data considered in assessments of network adequacy include member satisfaction with practitioner access and availability; complaint and grievance data; and cultural, ethnic, racial, and linguistic needs of the membership. Results are reported and reviewed by the Quality Committee. The Quality Committee or a designated subcommittee analyzes the data and makes recommendations to address deficiencies in the number, distribution, or type of practitioners available to the membership.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					Policy MS.QI.22, Cultural Competency, states a written Cultural Competency Plan is in place and describes activities and mechanisms to ensure the health plan and its provider network meet members'

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						linguistic and cultural needs. Provider-facing activities include: •Providing cultural competency training to subcontractors and providers quarterly. •Including information about cultural competency in the Provider Manual and on Magnolia's website. Providers may request a hard-copy at no charge. CCME confirmed the Magnolia Health Cultural Competency Plan is available on Magnolia's website. Magnolia conducts an annual evaluation of the effectiveness of the Cultural Competency Plan. Any identified issues are tracked and trended, and interventions to improve the provision of services are implemented.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The MSCAN Quality Management Program Evaluation 2020 indicates Magnolia continued strategic recruiting efforts targeting providers in locations for which specialty gaps were demonstrated. Monthly monitoring continues of geographic access, and this is reviewed quarterly by the Utilization Management Committee. By combining non-participating provider paid claims data and analysis of the DOM state file, additional providers were identified for outreach.
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Procedures for monitoring provider compliance with appointment access and after-hours access are included in Policy CC.PRVR.48, Evaluation of the Accessibility of Services. Magnolia measures appointment accessibility to primary care services, behavioral health services, and specialty care services annually. The Quality Committee, or a designated

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						subcommittee, analyzes the data and makes recommendations to address any deficiencies as needed. Methods and sources of data collection include but are not limited to CAHPS survey results; member complaints/grievances/appeals about access; site surveys or audits regarding access to primary care, behavioral health, and specialty appointments. An annual quantitative and qualitative analysis of performance against the established accessibility standards is completed. When goals are not met, the Quality Committee, or a designated subcommittee or workgroup, reviews the information for opportunities for improvement and recommends interventions as needed. Examples of interventions include educating the provider on required accessibility standards, expanding the network, working with individual practices to improve scheduling systems, and targeting a specific specialty or geographic area for special recruitment efforts. Results are reported at least annually to the Quality Committee, including the effectiveness of interventions, and reported at least annually in the Quality Program Evaluation. Results of appointment accessibility evaluation are included in overall network adequacy analysis. Appointment access standards are included in the Provider Manual and in the Member Handbook. Both are compliant with contractual requirements. An excel spreadsheet titled, "MSCAN Provider Appointment Availability_ Q2 2021" indicates 100% of primary care and obstetrics/gynecology providers contacted were compliant with appointment access standards. The document also indicates 100% of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						behavioral health providers contacted were compliant with appointment access standards.
II C. Provider Education *42 CFR § 438.414*						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy CC.PRVR.13, Provider Orientations: Newly contracted PCPs, specialists, hospitals, and ancillary providers who are not part of an existing in-network group or facility receive an orientation within 30 days of joining the network. Provider Orientation Core Elements are included as an attachment to the policy.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					The Provider Manual includes a detailed section about Magnolia's Care Management Program, including information about the High Risk Pregnancy Program, the SSI/Complex Teams, the Community Connections Program, and available Disease Management Programs.
2.2 Billing and reimbursement practices;	X					Information about billing and claims submission is found in the Provider Manual, including general billing guidelines, encounters, timely filing, claim payments, member billing, and procedures for claim submission, etc.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					The Provider Manual includes a table listing benefits covered by Magnolia, including notations regarding limitations, coverage requirements, etc. The Provider Manual also includes a listing of value added benefits provided by Magnolia and a table listing non-covered services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					Appointment access standards are documented in the Provider Manual.
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					The Provider Manual states PCPs and specialists must identify and reschedule broken and no-show appointments. Providers are required to document the reason for noncompliance with EPSDT screenings and services, where possible, and to document their efforts to bring the member's care into compliance with the standards.
2.8 Medical record handling, availability, retention, and confidentiality;	X					The Provider Manual includes a section about Medical Record Review that informs providers about medical record retention timeframes, confidentiality, medical record documentation requirements, medical record release and transfer, and requirements for medical record availability for audits conducted by Magnolia.
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					Magnolia's Provider Manual provides information about pharmacy services, requirements, etc. The Provider Manual directs the reader to the Magnolia website for additional information and includes information about the provision of a three-day emergency supply of medication while prior authorization is pending.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 Prior authorization requirements including the definition of medically necessary;	X					Information about prior authorization requirements is found in the Provider Manual, such as methods of requesting prior authorization, authorization timeframes, clinical information submission, medical necessity review and review criteria, etc. The reader is referred to Magnolia's website to view the list of services requiring prior authorization.
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					Information about the roles and responsibilities of PCPs is included in the Provider Manual. The Provider Manual documents provider types that may serve as a PCP, requirements for PCPs, assignment as a medical home, etc. Providers may contact Magnolia to request an assigned member be assigned to an alternate PCP, using Magnolia's Primary Care Provider (PCP) Form, available on the website. The Provider Manual does not list restrictions on a PCP's ability to request reassignment of a member to another PCP. *Recommendation: Include all pertinent information about PCP requests to reassign members to another PCP, including circumstances for this this is not an option, in the Provider Manual.*
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					As noted in Policy MS.PRVR.19, Provider Directory, Magnolia maintains both a print version and a searchable web-based provider directory. The web-based directory is updated within five business days of changes to the provider network. The print version of the Provider Directory is updated annually, or more often, if there are significant network changes. Magnolia performs usability testing of the web-based Provider Directory through the Member Advisory Committee or by random survey, conducted on an ad hoc basis and after any upgrades to functionality or design that directly affect how members or providers use the site. A review of the printed version and the online Provider Directory revealed all required elements are included. It was noted that many of the provider entries in the Provider Directory indicate details are pending for accommodations for people with physical disabilities. Onsite discussion revealed that a corporate initiative to gather and include this information was in progress but has been delayed by the COVID-19 pandemic.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, states Magnolia adopts preventive health guidelines (PHGs) from recognized sources that are relevant to the member population. The PHGs are reviewed by the Quality Committee to ensure appropriate physician input and are updated at least annually and when there is significant new scientific evidence or changes in national standards. Board-certified practitioners provide input through Magnolia's Quality Committee. The guidelines are reviewed at least annually.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					According to Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, Magnolia distributes guidelines to all applicable providers via new practitioner orientation materials, newsletters, special mailings, etc. Magnolia's Provider Manual includes information about the PHGs and directs the reader to the website for a full list of preventive health guidelines. The link included in the Provider Manual (www.magnoliahealthplan.com/providers/quality-improvement/practice-guidelines) is incorrect and takes the user to a page that only says "ERROR." However, the guidelines were found by searching the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Revise the Provider Manual to include the correct URL for the preventive health guidelines on Magnolia's website.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, states Magnolia adopts clinical practice guidelines (CPGs) that are based on the member population's health needs and/or opportunities for improvement identified through the Quality Assessment and Performance Improvement (QAPI) Program. Guidelines are reviewed by the Quality Committee to ensure appropriate physician input and are updated at least annually and when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						there is significant new scientific evidence or changes in national standards.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.	X					According to Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, Magnolia distributes guidelines to all applicable providers via new practitioner orientation materials, newsletters, special mailings, etc. Magnolia's Provider Manual includes information about the CPGs and directs the reader to the website for a full list of preventive health guidelines. As noted above, the link included in the Provider Manual is incorrect and takes the user to a page that only says "ERROR." However, the guidelines were found by searching the website. A recommendation to address this was included in standard II (D) 2 above.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy MS.QI.13, Medical Record Review, describes processes used to monitor provider medical record maintenance and compliance with minimum standards. The policy defines the medical record retention timeframe as at least 10 years for adults and at least 13 years for minors. The policy includes a copy of the Medical Record Audit Tool.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					At least annually, Magnolia conducts an assessment of provider compliance with established medical record keeping standards. Elements scoring below 90% are considered deficient and in need of improvement. Upon completion of the audit, preliminary results are reviewed with the office contact and written notification of the outcome is mailed to the provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						within 15 days, including the overall score, areas of deficiency, a copy of the completed/scored audit tool, and an action plan for improvement if necessary. A follow-up audit is conducted within six months for overall scores below 90%. Reaudit scores that remain below 90% are discussed with the Vice President of Medical Management and/or Chief Medical Director for further action. Medical record review results are maintained by the QI Department and shared with the Credentialing Department for consideration at recredentialing. Reviews are trended by the QI Department to determine plan-wide areas in need of improvement and may be addressed via network-wide and/or provider-specific education. An aggregate summary of medical record reviews completed and are presented quarterly to Magnolia's Quality Committee. A narrative document submitted in the desk materials stated, "Medical Record Reviews are still in progress for 2021. Final analysis and report will be submitted to the Quality Improvement Committee in October 2021 after completion of audits."
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					Based on the 2020 Provider Satisfaction Report by SPH Analytics, the total sample size of2,000, 183 responded for a 9.2% response rate. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.1% (51 out of 282). No measures had a significant decline. Six measures had a significant increase: rating of health plan,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						access to knowledgeable UM staff, procedures for precertification, timeliness for precertification, health plan's facilitation for clinical care for patients, and ease of prescribing preferred medications. 79% of providers were somewhat or completely satisfied. The net satisfaction score was 71% and the net loyalty score was 57%. *Recommendation: Analysis of barriers to gathering survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the PCP, specialist, and behavioral health provider population on the satisfaction surveys.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100*						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MS.MBRS.25, Member Rights and Responsibilities, the Member Handbook, the Provider Manual, and Magnolia's website provide all member rights and responsibilities clearly.
2. Member rights include, but are not limited to, the right:	X					Policy MS.MBRS.25, Member Rights and Responsibilities, describes member rights.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					Policy MS.MBRS.25, Member Rights and Responsibilities, lists member responsibilities.
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					Policy MS.MBRS.01, New Member Packet/Member ID Card, and Policy MS.MBRS.02, Member Handbook, state that members are provided, a New Member Packet within 14 days after Magnolia receives the member's enrollment data from DOM.
1.1 Full disclosure of benefits and services included and excluded in coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						Limits of coverage, maximum allowable benefits, and no cost services for routine, urgent, and emergent healthcare needs are outlined in the Member Handbook.
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook and Magnolia's website provide information instructing members on the appropriate level of care for routine, urgent, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						emergent healthcare needs for medical, dental, and behavioral health services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						The Member Handbook includes information about obtaining prescription medications and durable medical equipment. The Preferred Drug List and participating pharmacies are available on the member website.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						Policy MS. MBRS.12, Member Notification of Plan Changes, indicates members are notified of changes to the program no later than 30 calendar days prior to implementation. This is also described in the Member Handbook.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						Contact information for the 24-Hour Nurse Advice Line and information about the secure member portal and the MyMagnolia Mobile App are provided in the Member Handbook with support provided by Member Services. The Call Center team educates and gives information about the member portal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.13 A description of EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						Disenrollment processes are referenced in the Member Handbook. Members may make requests to the Call Center or to DOM directly.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						Members are provided with information about the Fraud, Waste, and Abuse program and options for reporting instances of suspected FWA anonymously and in various formats in the Member Handbook and on the website.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						The Mississippi Advance Health Care Directive Form is available for members and is located on the Mississippi State Department of Health's website. Information on Advanced Directives is also covered in the Member Handbook.
1.20 Additional information as required by the contract and by federal regulation.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Member program materials use a minimum 12-point font and items requiring large print are printed in 18-point font. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. Member material guidelines are outlined in Policy MS.MBRS.06, Member Materials Readability and Translation, to ensure materials are written in a clear and understandable manner and meet contractual requirements.
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Policy MS.MBRS.03, Impaired/Language-Specific Interpreter Services, and Policy MS.MBRS.06, Member Materials Readability and Translation, provide information to members on ways to obtain translated materials and assistance.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					Members are provided with a toll-free access number, an automated voice system, or a live person to address questions or concerns. Policy MS.MBRS.10, Member Service Calls/Hotline, and Policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						MS.PRVR.03, Toll-free Provider Telephone Hotline, state Magnolia maintains a toll-free Member Services and Provider Services call center as required. The 24-Hour Nurse Advice Line is available 24 hours a day, 7 days a week, including holidays. Call Center hours of operation are consistently identified on the Magnolia website, in the Member Handbook, and in the Provider Manual.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					The Call Center staff have appropriate call scripts and work processes to assist members and providers, such as scripts for Member Returning Calls, Handling BH Crisis Calls, Provider Services Escalation, and Pharmacy Calls. Call Center staff receive training at least quarterly with training logged. CCME discussed that recorded calls are used as training tools for quality improvement efforts.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Policy MS.PRVR.24, Member & Provider Call Audit and Quality Criteria and Protocol, indicates that Call Center activity is monitored and evaluated for member incoming and outgoing calls.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MS.ELIG.05, Disenrollment, outlines that regarding disenrollment, the Plan will comply with the *CAN Contract*, Section 4.
III E. Preventive Health and Chronic Disease Management Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					Magnolia ensures the provision of screening, preventive, and medically necessary diagnostic and treatment services for members through the month of their 21st birthday, as stated in Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service, and Policy MS.QI.20.01, EPSDT Notification System. Policies describe processes and methods for notification, tracking, and follow-up of the EPSDT program and address barriers of low utilization by creating interventions to encourage members to use the services.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					CCME discussed the efforts made by the Community Relations team in the community. Opportunities for in-person events are in place, when possible, to provide education “where members live, work, play, and worship.” Books, booklets, school and parent collaboration, and provider groups are offered as resources. Population Health Department collaborates with information specific to age by phone, Start Smart for Your Baby® events, resources, website, disease management, and health coaching.
III F. Member Satisfaction Survey						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The CCO conducts a formal annual assessment of member satisfaction that meets all requirements of the CMS Survey Validation Protocol. Magnolia contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems Survey vendor, to conduct the Adult and Child Surveys. The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult, Child, and Child CCC CAHPS surveys. For Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (15.9%) with 214 completed surveys out of a sample of 1,342. For the Child survey, generalizability of the survey results is also difficult to discern due to low response rates (9.4%) with 216 completed surveys out of 2,310 sampled. For the Child CCC survey, generalizability of the survey results is also difficult to discern due to low response rates. The general population surveys were 355 out of 1,650 for a 10.2% response rate. The total population completed surveys were 161 for a 9.8% response rate. *Recommendation: Continue to work with SPH Analytics to improve response rates. Determine if there are other innovative ways to advertise surveys and increase response rates.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Magnolia analyzes data obtained from the Member Satisfaction Survey to identify quality problems, as noted in the Mississippi Coordinated Access Network (MSCAN) Quality Management Program Evaluation 2020.
3. The CCO reports results of the member satisfaction survey to providers.	X					The plan reports the results of the Member Satisfaction Survey to providers as seen in the Fall Provider Newsletter DRAFT.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The CCO reports results of the Member Satisfaction Survey, and the impact of measures taken to address any quality problems that were identified, to the correct committee as noted in the QMC August 2021 minutes.
III G. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F*						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					
1.1 Definition of a grievance and who may file a grievance;	X					The term “grievance” is correctly defined in Policy MS.MBRS.07, Member Grievance and Complaints Process, the Magnolia website, the Member Handbook, and the Provider Manual.
1.2 The procedure for filing and handling a grievance;	X					A grievance can be filed at any time as outlined in Policy MS.MBRS.07, Member Grievance and Complaints Process, the Member Handbook, the Provider Manual, and website. Information is provided on ways to file a grievance verbally or in writing. Grievances will be acknowledged in writing within five calendar days. Information for filing by an

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Authorized Representative was referenced in policy and on the Magnolia website.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy MS.MBRS.07 was revised based on last year's recommendation to indicate that "A copy of verbal complaints logs and records of disposition or written grievances shall be retained during the entire term of the Contract and for ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress" to meet contractual requirements.
2. The CCO applies the grievance policy and procedure as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					Grievances are tracked and analyzed for medical and behavioral health services, with results reported to the QIC quarterly, as noted in Policy MS.MBRS.07, Member Grievance and Complaints Process. The QIC reviews grievance trends to identify areas for quality improvement.
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					Policy MS.ELIG.03, PCP Selection and Change, describes Member Services staff assist members with PCP change requests for any reason including dissatisfaction.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 and 42 CFR Part 441, Subpart B*						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Magnolia provided the 2021 MississippiCAN Quality Management Program Description. This QI Program Description included the program's objectives or priorities and goals, the program's structure, and scope. Magnolia's Board of Directors has authority, responsibility, and oversight of the development, implementation, and evaluation of the Quality Program. The Board is responsible for evaluating the QI Program Description and the Quality Work Plan to assess whether program objectives were met and recommends adjustments when necessary. At least annually, Magnolia provides information to members and providers regarding the QI Program. On the Magnolia website, a copy of the 2021 QI Program Description and information regarding how to obtain information on the program evaluation was included.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The QI Program Description describes Magnolia's efforts to reduce health disparities through their cultural competency program. Magnolia also assesses and identifies interventions to address health disparities at statewide and regional levels.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Magnolia monitors utilization patterns by performing assessments of utilization data to identify potential over- and under-utilization issues or practices using various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					Magnolia develops a QI Work Plan annually after completing the Quality Program Evaluation for the previous year. The 2020 and 2021 QI work plans were provided for review. Both work plans included all ongoing QI activities, the responsible party, and target or completion dates. The work plan is presented to the QIC at least annually for review and approval.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Board delegates the operating authority of the QI Program to the QIC. Magnolia's senior management staff, clinical staff, and network practitioners serve on the QIC and are involved in the implementation, monitoring, and direction of relative aspects of the QI Program. The QIC is the senior leadership committee accountable to the Board of Directors. The purpose of this committee is to perform oversight of all Magnolia's QI activities. This committee is responsible for the review and monitoring all clinical, physical, quality activities, to assess the appropriateness of care delivered and to continuously enhance and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						improve the quality of services. The QIC acts as an oversight committee and receives reports from all Magnolia sub-committees. The Performance Improvement Team is an internal cross functional quality improvement team. This team is responsible for gathering and analyzing data, identifying barriers, resolving problems, making recommendations, and reporting to the QIC. Magnolia's Quality Task Force committee is responsible for monitoring HEDIS rate trends, identifying data concerns, and directing interventions.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Chief Medical Director chairs the QIC. Voting members include Magnolia's senior leaders representing all departments of the organization and five network providers. Their specialties include Pediatrics, Family Practice, Psychiatry, and a family nurse practitioner.
3. The QI Committee meets at regular intervals.	X					The QIC meets at least quarterly. However, additional meetings may be scheduled as needed. A minimum of five members including three plan staff and two external physicians must be present for a quorum.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes for each meeting are drafted and distributed within 30 days of the meeting. The minutes are approved at the next scheduled meeting.
IV C. Performance Measures *42 CFR §438.330 (c)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					The performance measure validation found that Magnolia was fully compliant with all information system standards and that Magnolia submitted valid and reportable rates for all HEDIS measures in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						scope of this audit. During the audit process, it was noted by Magnolia's HEDIS auditor that Magnolia needed to improve its processes for providing data for various audit steps in a timely manner to avoid the risk of missing critical NCQA deadlines. There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Magnolia followed the measure specifications and produced reportable rates for all measures in the scope of the validation. Magnolia did not report the Sealant Receipt on Permanent First Molars (SFM-CH) non-HEDIS measure as required by DOM and was unable to provide responses for rate comparison concerns effectively. Details of the validation activities and recommendations for the Performance Measures may be found in *Attachment 3, EQR Validation Worksheets*. *Recommendation: Based on Magnolia's HEDIS auditor's findings in the Final Audit report, it is recommended that Magnolia improve processes for providing data for various audit steps in a timely manner. Also, improve processes around calculation, reporting and verification of the rates reported for the DOM required Adult and Child Core set measures.*
IV D. Quality Improvement Projects *42 CFR §438.330 (d)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					Magnolia submitted four PIPs for validation that addressed the DOM required topics. Topics included: Behavioral Health Readmissions, Reducing Preterm

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Births, Sickle Cell Disease Outcomes, and Asthma/COPD.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					All the PIPs scored in the "High Confidence in Reported Results" range. The Behavioral Health Readmissions, Sickle Cell Disease Outcomes, and the Asthma COPD PIPs demonstrated no quantitative improvement in process or care. Details of the validation for the Performance Improvement Projects may be found in *Attachment 3, EQR Validation Worksheets.* *Recommendation: Continue working on provider and member interventions for the performance improvement projects that demonstrated no quantitative improvements in process or care.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Per Policy MS.QI.23, Provider Profiling Program, Magnolia uses the Provider Profiling Program and Provider Analytics to measure provider performance. Measures include per member per month cost, utilization data, peer group comparisons, patient engagement analysis, quality measure trends, and readmissions. Monthly Provider Analytic dashboards are available in the Provider Analytics section of Magnolia's Provider Web Portal. The Medical Director or Quality Improvement Designee will meet with providers to discuss the dashboard results, identify barriers, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						determine what interventions are necessary for performance improvement.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Magnolia monitors compliance with preventive health and clinical practice guidelines through review of HEDIS measures, such as Diabetes Care, Prenatal and Postpartum Care, Childhood Immunizations, and Annual Child Wellness exams. Last year CCME received Policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines. According to Magnolia staff, this policy was retired and replaced with Policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines. This new policy addresses the development, adoption, revision, and performance monitoring.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						Magnolia provides coverage for a full range of Early and Periodic Screening, Diagnostic & Treatment (EPSDT) services as required by the *CAN Contract*. Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service, describes the process Magnolia uses to monitor compliance with the EPSDT program requirements and initiate interventions to improve compliance for providers and members.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					Per Policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment Periodic (EPSDT) Service, Magnolia's EPSDT Coordinator will monitor claims to identify members with any abnormal finding on an EPSDT screening. If there is no evidence that treatment was sought, the EPSDT Coordinator will

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						contact the provider and member to assist in arranging an appointment for follow-up. During the previous EQR, CCME recommended Magnolia update the EPSDT tracking report to identify members needing follow-up care after an EPSDT screening and to include the CPT codes and dates or notes regarding the contact made. The sample EPSDT tracking report provided for this EQR showed evidence this recommendation was implemented.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Magnolia's 2020 QI Program Evaluation summarizes the completed and ongoing QI activities and evaluates the overall effectiveness of the program. The 2020 QI Program Evaluation covers activities completed between January 1, 2020, and December 31, 2020. The Program Evaluation received for this EQR seemed to be a "draft." There were tracked changes or notes on page 90. According to Magnolia, this copy was a final and had been approved by the QIC. Overall, the program evaluation was well done, and no issues were noted.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. Utilization Management (UM) Program *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 208, 42 CFR § 208*						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The UM Program Description outlines the objectives, scope, and staff roles for Magnolia's Utilization Management (UM) Program for physical health, behavioral health, and pharmaceutical services.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Program Description describes the roles and responsibilities of the Chief Medical Director and other Medical Directors for physical and behavioral health services. Responsibilities include but are not limited to, supervising medical necessity decisions, conducting Level II reviews, and participating in committees.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Chief Medical Director is responsible for chairing the Utilization Management Committee. The Vice President of Population Health and Clinical Operations is responsible for the daily management of the UM activities.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The Population Health Management and Clinical Operations Department evaluates the UM Program to assess its strengths, effectiveness, and opportunities for improvement. The evaluation and recommendations are presented to the Utilization Management Committee (UMC) and QIC for review and approval. UM criteria is reviewed and approved annually and updated as needed. Magnolia confirmed the 2020 Utilization Management Program Evaluation was approved on September 27, 2021. Magnolia staff explained that network providers participate on the Clinical Policy Committee (CPC) where clinical policies and guidelines are presented, which is confirmed by CPC minutes and in the Committee Charter.
V B. Medical Necessity Determinations						
1. Services that require prior authorization by the CCO include only the services specified by the Mississippi Division of Medicaid.	X					
2. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					The UM Program Description, Policy MS.UM.02, Clinical Decision Criteria, and Policy MS.UM.02.01, Medical Necessity Review, describe and outline process used to make UM determinations. Magnolia utilizes McKesson's InterQual guidelines for inpatient and outpatient medical services. ASAM

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						criteria and InterQual are used to render behavioral health determinations.
3. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files reflected consistent decision-making, according to an established hierarchy, utilizing standards such as InterQual, Magnolia's policies, clinical guidelines, pharmacy guidelines, and relevant medical information.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, describes that members' individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. Approval files reflect that physician reviewers will use manual criteria and their clinical professional judgement to consider the member's individual circumstances when InterQual criteria is not met.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					The VP of Population Health and Clinical Operations ensures annual InterQual Inter-rater Reliability Testing (IRR) is conducted for physicians, and nurse reviewers as described in the UM Program Description. 41 nurses and four Medical Directors achieved passing scores of 90% or greater during 2020. A remediation plan is in place for reviewers who do not pass. Onsite discussions confirmed behavioral health reviewers are tested separately with behavioral health criteria and received passing scores.
6. Pharmacy Requirements						
6.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Policy MS.PHAR.09, Pharmacy Program, states Envolve Pharmacy Solutions is the pharmacy benefit manager and is responsible for implementing all

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						pharmaceutical services for Magnolia, including but not limited to prior authorizations and pharmacy network management. The Universal Preferred Drug List specified by DOM indicates over-the-counter (OTC) availability, age, or quantity limitations, and if step therapy is required. A link to access the most current version of PDL is available on Magnolia's website. The user is automatically directed to DOM's website, where the PDL is available in a searchable, electronic format. Additionally, the PDL can be downloaded and printed, or hard copies can be requested by calling Members Services.
6.2 The CCO has established policies and procedures for prior authorization of medications.	X					Envolve Pharmacy Solutions conducts the prior authorization process according to state, federal, and regulatory requirements and notification is provided to the requesting provider within 24 hours, as indicated in Policy MS.PHAR.09, Pharmacy Program. Magnolia ensures a three-day supply of medication will be approved while a prior authorization request is pending.
7. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The UM Program Description and Policy MS.UM.12, Emergency Services, describe emergency and post-stabilization service requirements and the member's ability to access them. Magnolia does not require prior authorization for physical health or behavioral health emergency hospital services. Additionally, the Member Handbook and the website provide instructions for members to freely access emergent and urgent care services.
8. Utilization management standards/criteria are available to providers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. Utilization management decisions are made by appropriately trained reviewers.	X					The UM Program Description and Policy CC.UM.04, Appropriate UM Professionals, describe Magnolia's approach to ensuring UM decisions are conducted by qualified staff who are trained in the principles, procedures and standards of utilization and medical necessity review. Initial clinical reviews are performed by Mississippi-licensed nurses and Level II clinical reviews are performed by a Mississippi-licensed physician or other appropriate healthcare practitioner. Non-licensed staff perform intake and initial screenings that do not require clinical interpretation and are required to refer clinical cases to clinical staff.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of approval files reflect physical and behavioral health utilization decisions are determined within required time frames. Urgent service authorization requests are determined and communicated to providers within 24 hours and standard requests are communicated within three calendar days/ two business days.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files reflected clinical reviewers appropriately request additional information from providers prior to making an adverse benefit determination. Providers are given a specified timeframe to submit this information.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files indicate Magnolia ensures denial decisions are reviewed and determined by an appropriate physician. Clinical reviewers forward requests to a medical director or appropriate physician specialist when requests do not meet medical necessity criteria and cannot be approved.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Additionally, denials for pharmacy requests are reviewed by a licensed pharmacist and signed off by a health plan medical director.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files reflected adverse benefit determinations are rendered according to the processes described in Policy MS.UM.07, Adverse Benefit Determinations and Notifications. Determinations were communicated verbally to the requesting provider. An adverse benefit determination letter, mailed to the provider and member, explains the basis for the denial and includes appeal procedures.
V C. Appeals *42 CFR § 438.228,42 CFR § 438, Subpart F*						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					The UM Program Description and policies such as Policy MS.UM.08, Appeal of UM Decisions, and Policy MS.UM.01, Utilization Management Program Description, describe Magnolia's approach for handling and processing member appeals. Additionally, information is provided in the Provider Manual, in the Member Handbook, and on the member tab of the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The terms "adverse benefit determination" and "appeal" and information about who may file an appeal are correctly defined and described in the UM Program Description, in Policy MS.UM.08, Appeal of UM Decisions, in the Provider Manual, and on the website, which addresses the Corrective Action Plan identified in the 2020 EQR.
1.2 The procedure for filing an appeal;	X					Procedures for filing an appeal are described and outlined in Policy MS.UM.08, Appeal of UM Decisions. Magnolia ensures members and their

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						representative have access to appeals information, processes, and procedures by making it available on the member facing website. Onsite discussions confirmed Member Services can provide appeals information in Spanish upon request and provides a Spanish speaking interpreter.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy MS.UM.08, Appeal of UM Decisions, correctly documents the resolution timeframe for standard and expedited appeals. Standard appeal requests are resolved within 30 calendar days, expedited appeals are resolved within 72 hours, and either timeframe can be extended up to 14 calendar days by the member or by the plan.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					Policy MS.UM.08, Appeal of UM Decisions, and the Member Handbook provide instructions and requirements for the continuation of benefits while an appeal or State Fair Hearing is pending.
2. The CCO applies the appeal policies and procedures as formulated.	X					Review of appeal files reflect Magnolia staff are following documented appeals guidelines and processes. Onsite discussion confirmed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						pharmaceutical appeal request are reviewed by Magnolia's pharmacist and signed-off by the Medical Director.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MS.UM.08, Appeal of UM Decisions, explains appeals are tracked, trended, analyzed, and reported quarterly to the QIC. QIC meeting meetings reflected detailed discussions and reporting of physical health, behavioral health, and pharmaceutical appeals results. Behavioral health appeals remained a delegated function to Centene Behavioral Health. The 2020 Utilization Management Program Evaluation reports that out of 448 total appeals, 44% were overturned when the provider submitted additional clinical information, and 56% were upheld because the requested service was not a covered benefit or documentation submitted did not support medical necessity criteria.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Magnolia has an established Care Management Program and Population Health Management Program to ensure and promote access and delivery of care management services for all members.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					The Care Management Program Description indicates eligible members can be identified for care management through data sources such as readmission reports, results of Health Risk Screenings, from Magnolia's predictive modeling

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						software, and through referral into case management.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					A health risk assessment will be completed within 30 calendar days after a member is appropriately identified and a Care Treatment Plan will be completed within 30 calendar days after the HRA if the member is assigned to as Moderate Level, Complex Care, or Transitional Care Management as described in the Care Management Program and the UM Program Description.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					The care treatment plan is developed in conjunction with the member, the member's authorized representative or guardian, authorized family members, the managing physician, and other members of the health care team. Behavioral health care coordination is incorporated into the care treatment plan as needed, as stated in the Care Management Program and Program Description.
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					Health risk assessments are conducted by qualified licensed health professionals, such as nurses and social workers, who are appropriate for the member's health condition.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Magnolia uses care management techniques to ensure members have access to required services and are provided with information on available services and how access to those services. The review of care management files reflected care management activities such as documentation of referral services, health education and support, appropriate referrals, and scheduling assistance.
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy MS.UM.24, Continuity and Coordination of Services, and the Care Management Program Description state that Magnolia will transfer the member's care management history, six months of claims history, and other pertinent information when a member disenrolls.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					Envolve People Care has disease management programs for conditions such as asthma, hypertension, and smoking cessation, etc. Disease Management Health Coaches collaborate with Care Management staff. Policy MS.CM.O2, Disease Management Programs, outlines Magnolia's Disease Management program.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					A high level of care management is provided to members in the Transitional Care Management program, who require services such as discharge planning and coordination of outpatient services.
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					Policy MS.CM.99, Transitional Care Management Process, describes Magnolia's approach for ensuring transitional care management is accessible to eligible members and outlines processes and requirements for managing transitions of care across healthcare and community settings.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					The interdisciplinary transitional care team coordinates and manages required services to ensure continuity of care and to prevent duplication of services as members return their home or other community setting. Policy MS.CM.99, Transitional Care Management Process, explains that the team includes, but is not limited to, RN Care Managers, Behavioral Health staff, and Social Services Specialists.
4. The CCO meets other Transition of Care requirements.	X					Documentation in Policy MS.CM.99, Transitional Care Management Process, and Policy MS.UM.24, Continuity and Coordination of Services, indicates Magnolia meets other transition of care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						requirements as noted in the *CAN Contract, Section 8 (B) (5).* There is a brief description on transition of care process in the Member Handbook and members are instructed to call Member Services for more information.
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					Magnolia performs an evaluation of the UM Program annually. The 2020 UM Program Evaluation provides a summary of UM program activities and reports, an analysis of measurement outcomes, a determination of the overall effectiveness of the UM Program and offers recommendation for improvement for 2021.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230*						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Magnolia has delegation agreements in place with the following vendors: •Envolve Dental •Envolve Vision •Envolve Pharmacy Solutions

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• Envolve PeopleCare-NurseAdvice Line •Medical Transportation Management, Inc. (MTM) •National Imaging Associates, Inc. (NIA) Delegation agreements are in place with the following entities for credentialing and recredentialing activities: •Baptist Memorial Health Care-Baptist Health Services Group •Hattiesburg Clinic, PA •LSU Healthcare Network (New Orleans) •Magnolia Regional Health Center •Management and Network Services, LLC •Memorial Hospital at Gulfport •Mississippi Health Partners •Mississippi Physicians Care Network •North Mississippi Medical Clinic/North MS Healthlink •Ochsner Clinic Foundation •Premier Health, Inc. •Rush Health Systems •St. Judes Children's Research Hospital •University of Mississippi Medical Center The agreements specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed	X					Processes for assessing a potential delegate's capabilities to conduct the delegated service, as well as processes for annual oversight and ongoing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
using standards that would apply to the CCO if the CCO were directly performing the delegated functions.						monitoring for established delegates, are found in Policy MS.QI.14, Oversight of Delegated Vendor Services, and Policy CC.CRED.12, Oversight of Delegated Credentialing. Documentation of preassessment activities, annual oversight, and ongoing monitoring were provided for each of Magnolia's delegated vendors. Tools used in the monitoring and oversight were also submitted. Reports of the monitoring and oversight included documentation of any deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan.